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# ROYAL COMMISSION ON HEALTH SERVICES

## PRELIMINARY MEETING

HELD AT

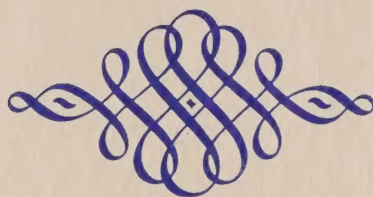
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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the preliminary hearing held at Ottawa, commencing Wednesday, September 27th, 1961.

COMMISSION MEMBERS:

Chief Justice EMMETT M. HALL -- Chairman

Miss ALICE GIRARD, R.N.

Dr. DAVID M. BALTZAN

Prof. O.J. FIRESTONE

Mr. M. WALLACE McCUTCHEON, Q.C.

Dr. C.L. STRACHAN

Dr. ARTHUR F. VAN WART

COMMISSION COUNSEL:

Mr. R.M. HALL, Q.C.

MEDICAL CONSULTANT:

Dr. PIERRE JOBIN

DIRECTOR OF RESEARCH:

Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE

-----







Ottawa, Wednesday, 1  
September 27th, 1961

dpw

1 --- On commencing at 9.45 a.m.

2 THE CHAIRMAN: Ladies and gentlemen, I  
3 crave your indulgence for having been delayed a few  
4 minutes on account of people who are coming in so that  
5 they might have an opportunity to be seated.

6 The first thing we want to do is to file  
7 with our Secretary, Major Lafrance, the Commission under  
8 the Great Seal of Canada appointing the Commissioners to  
9 act in accordance with the terms of the Order in Council.

10 EXHIBIT NO. 1: The Commission under the  
11 Great Seal of Canada.

12 I would like to introduce my fellow Commis-  
13 sioners, starting on my right:

14 Dr. D.M. Baltzan of Saskatoon

15 Miss Alice Girard of Montreal

16 Dr. Firestone of Ottawa

17 Mr. Wallace McCutcheon, Q.C., of Toronto

18 Dr. Van Wart of Fredericton

19 Dr. Strachan of London, Ontario

20 Then we have with us as officers and assis-  
21 tants to the Commission:

22 Our medical consultant, Dr. Jobin of Quebec  
23 City; as counsel to the Commission, R.M. Hall, Q.C. of  
24 Prince Albert; as our research director, Professor Bernard  
25 Blishen on loan to the Commission from the University of  
26 British Columbia; and our Secretary, Major Norman Lafrance.

27 Ladies and gentlemen, I would like to open  
28 the proceedings with a statement.

29 This is the first public hearing held by the  
30 Royal Commission on Health Services. It is a preliminary







1 hearing designed to prepare the ground for the Commission's  
2 work, including the holding of full public hearings in the  
3 major cities of Canada, and to listen to suggestions and  
4 observations made by those wishing to participate in the  
5 work of the Commission.

6 Perhaps I might start by setting out briefly  
7 the scope of the assignment which the Federal Government  
8 has entrusted to the Royal Commission on Health Services,  
9 the manner in which we are planning to comply with our  
10 Terms of Reference and the procedures this Commission will  
11 follow.

12 I shall then outline the purpose of this  
13 preliminary hearing, the manner in which written submis-  
14 sions and oral presentations can be most helpful to our  
15 Commission, and the opportunities that will be given to  
16 all those wishing to participate to be heard and to make  
17 suggestions with respect to the areas that our Commission  
18 can reasonably be expected to cover in its inquiry and  
19 with respect to the substance of our Terms of Reference.

20 1. Terms of Reference

21 The Royal Commission on Health Services was  
22 established by the Canadian Government by Order in Council  
23 1961-883 dated June 20, 1961:

24 "To inquire into and report upon the existing  
25 facilities and the future need for health  
26 services for the people of Canada and the  
27 resources to provide such services, and to  
28 recommend such measures, consistent with  
29 the constitutional division of legislative  
30 powers in Canada, as the Commissioners







1 believe will ensure that the best possible  
2 health care is available to all Canadians".

3 The Commissioners are authorized to exer-  
4 cise all the powers conferred upon them by Section 11 of  
5 the Inquiries Act which include the holding of public  
6 hearings and the calling and questioning of witnesses.

7 The Order in Council spells out the Terms  
8 of Reference under twelve specific headings, including a  
9 residual clause which reads:

10 "Such other matters as the Commissioners  
11 deem appropriate for the improvement of  
12 health services to all Canadians".

13 The general scope of the inquiry and the  
14 major areas to be covered is made clear in the Order in  
15 Council. We would like, however, to draw the attention  
16 of the public to clause (1).

17 There may be aspects of the inquiry which  
18 are not specifically mentioned in our Terms of Reference  
19 but which are important to cover fully to achieve the  
20 objective of our inquiry of "ensuring that the best possible  
21 health care is available to all Canadians". The Commission  
22 would like to be advised of such aspects in line with  
23 paragraph (1) of the Order in Council so that it can plan  
24 its work, hearings and studies accordingly.

25 2. Objectives

26 The objectives of the inquiry entrusted to  
27 our Commission are very broad. They affect the personal  
28 life of every Canadian. They deal with the medical profes-  
29 sion and associated professional and health service person-  
30 nel. They relate to existing health schemes operated by





1 private and public organizations, and new programs that  
2 might be developed. They touch on the personal, educa-  
3 tional, social, economic and constitutional aspects of  
4 the nation's life.

5           In the stage of economic and social develop-  
6 ment which Canada has reached, as is the case in many  
7 other Western countries, the desire for good health has  
8 become universal. The view appears to be developing,  
9 taken into account increasingly by governments, that  
10 opportunity for good health is a right possessed by all  
11 and should become available in one form or another to every  
12 citizen of Canada.

13           When protracted illness, accidents or  
14 disease strike a family the cost of medical care, hospita-  
15 lization, nursing, drugs and other services may be so high  
16 as to represent a serious financial burden in cases where  
17 no or inadequate protection is provided. Or, alternatively,  
18 inadequate steps may be taken to obtain proper health care,  
19 either when sickness occurs or on a preventative basis.  
20 The end result may be a lower health standard for Canada  
21 than resources and changing circumstances may permit.

22           There are, however, not only personal and  
23 social aspects to the subject of the health of the  
24 Canadian nation. There are also important economic impli-  
25 cations.

26           If the bread-winner of a family takes sick  
27 he will be out of work and likely not have much income,  
28 if any. People who do not work do not produce goods and  
29 services. The nation's output as a whole will be less  
30 than it would have been had proper health care either







1 prevented or reduced the incidence of sickness. A  
2 decrease in the nation's output resulting from inadequate  
3 health care, if of significant proportions, may be a major  
4 economic loss that cannot be made up.

5           The result: inadequate health care means a  
6 lower standard of living. Adequate health care means a  
7 higher standard of living. Ill health may be the largest  
8 economic waste the nation can experience. The question  
9 before us is: Can Canada afford that waste?

10           There is at this time in our history a  
11 consciousness of health needs and services at all levels  
12 of government. Since this is a vital problem government  
13 wants to know what should be done to achieve the legiti-  
14 mate needs of the Canadian people in the field of health  
15 services; what will the cost be; how can those needs be  
16 met in the light of our constitutional division of legis-  
17 lative powers in Canada; how to correlate and integrate  
18 the existing services in any national program; how to  
19 secure, train, qualify and compensate the practitioners  
20 and specialists needed in Canada in the coming years; the  
21 feasibility and the desirability of priorities in the  
22 development of health care services -- all as set out in  
23 the Order in Council which established the Commission and  
24 the whole against the background of what Canada can afford  
25 to do and the methods of financing any new or extended  
26 program which may be recommended.

27           This is the task which the Government has  
28 entrusted to the Commission, and this is the task to which  
29 the Commission will direct its efforts.

30           The inquiry we hope will be a searching one,







1 full, fair and flexible. We are interested in doing an  
2 objective and good job for the Canadian people. We want  
3 to search out the facts, we want to present them simply  
4 and clearly and indicate the health problems Canadians  
5 face. And, we hope to be able to come up with some reason-  
6 able recommendations as to what can be done about those  
7 problems, not just for the immediate future, but also over  
8 the longer term.

9 To achieve these objectives we require the  
10 full co-operation of Governments at all levels, the  
11 Canadian public, the professional organizations, business,  
12 labour and agricultural groups, universities, financial  
13 institutions and others. We shall seek this co-operation  
14 with all the means at our disposal in the interest of doing  
15 the best possible job to further the health of the Canadian  
16 people.

### 17 3. Constitutional Aspects

18 I would like to elaborate on one particular  
19 aspect of our Terms of Reference - the constitutional  
20 aspects of health.

21 Our Commissioners have been asked by the  
22 Federal Government to make recommendations, and I quote  
23 from the Order in Council, "consistent with the constitu-  
24 tional division of legislative powers in Canada".

25 The field of health and health services is  
26 largely under provincial jurisdiction. The Federal Govern-  
27 ment performs a number of health functions in specialized  
28 fields. However, in recent years, particularly since the  
29 Second World War the Federal Government has provided  
30 substantial assistance in the health field, largely through





1 the use of a grant system, either outright grants or  
2 matching grants.

3 Our Commission feels that clarification of  
4 the federal-provincial relations in the health field is a  
5 particularly important one. We will welcome an expression  
6 of views held by provincial governments, their advice and  
7 suggestions as to the best means of using the resources  
8 available for health care to the greatest possible bene-  
9 fits for the Canadian people in every part of Canada.

10 In particular we would find it most helpful  
11 to obtain an expression of views from provincial govern-  
12 ments as to the federal-provincial co-operation in the  
13 health field presently in existence and specific proposals  
14 in improving the existing system, the methods by which it  
15 could be achieved, the financing involved, the administra-  
16 tion concerned and related matters.

17 If any provincial representatives present  
18 today have any preliminary views to express on this subject  
19 at this time, we shall be glad to have them. There will  
20 be further opportunities for expression of such views  
21 either in the form of submissions or when public hearings  
22 are held in provincial capitals. We can assure the  
23 provincial governments that their views will be given  
24 every consideration and they will assist materially this  
25 Commission in directing its inquiries into the most cons-  
26 tructive channels of practical application.

27 4. Procedures

28 Prior to this meeting, shortly after we had  
29 our organization meeting, this Commission invited about  
30 1,000 organizations, institutions, governments and other







1 groups to participate in the work of the Commission. In  
2 addition, the Commission has advertised and continues to  
3 advertise its public hearings asking the public generally  
4 to make submissions or to appear as witnesses at the  
5 hearings.

6 The response so far has been very encoura-  
7 ging, well over 500. We are hopeful for further co-opera-  
8 tion as we hold hearings in every province of Canada.

9 The Commission is also initiating a number  
10 of research studies by specialists in specific fields.  
11 Thus we hope to be able to marshall the best expert know-  
12 ledge available on the subject of health in Canada and to  
13 make use of it in preparing our report. We are also  
14 planning to publish as supplementary documents to the  
15 Commission's report those studies whose content and  
16 quality contribute to our knowledge of the various aspects  
17 of health methods affecting Canadians.

18 5. Public Hearings

19 The Commission is planning on holding three  
20 types of public hearings:

21 (a) The preliminary hearing which has been  
22 called for today here in Ottawa and I shall  
23 elaborate on its purpose shortly.

24 (b) Public hearings will be held in every  
25 province of Canada. The first of such  
26 hearings have been arranged for the Atlantic  
27 Provinces. The dates and places of the  
28 hearings have been published in the daily  
29 press of those provinces. They are as  
30







1 follows:

2 Halifax, Nova Scotia, we start on October 30

3 St. John's, Newfoundland November 2

4 Charlottetown, Prince Edward  
Island November 7

5 Fredericton, New Brunswick November 9

6 We are planning to hold public hearings in  
7 Manitoba and Saskatchewan in January of 1962,  
8 in Alberta and British Columbia in February  
9 1962, in Ontario and Quebec from the middle  
10 of March to the middle of May next year.

11 The dates and places will be announced and  
12 published in the press. We hope that this  
13 tentative time schedule announced now at  
14 this early date will assist organizations  
15 and others wishing to make submissions to  
16 plan their work accordingly.

17 (c) Then, on completion of the hearings  
18 across Canada, a final public hearing will  
19 be held in Ottawa giving organizations and  
20 others an opportunity to submit supplementary  
21 briefs, rebuttals, and additional arguments  
22 and recommendations to insure that every  
23 worthwhile suggestion and proposal will get  
24 its full hearing and be considered by the  
25 Commission.

26 We will use the following procedures at the  
27 public hearing.

28 Briefs will be presented by a responsible  
29 officer of the organization concerned or the individual  
30





1 wishing to make the submission, or their legal counsel.  
2 Participants will be permitted to have expert witnesses  
3 appear on their behalf.

4           The full text of the submissions will be  
5 taken as read. In other words, the Commission undertakes  
6 that its members will have read the briefs before the  
7 hearings at which those briefs will be presented. At the  
8 hearings participants will be asked to present the conclu-  
9 sions contained in their submissions as well as their  
10 recommendations. They are free to elaborate orally and  
11 present arguments. Persons appearing before the Commis-  
12 sion may be examined directly by the Commissioners and by  
13 counsel for the Commission on the material submitted in  
14 their briefs and the recommendations put forward but they  
15 will not be subject to examination or cross-examination  
16 by other parties.

17           The proceedings of the hearings held by the  
18 Royal Commission will be recorded. Copies of these trans-  
19 crips may be purchased.

20 6. Submissions

21           The Commission is most anxious to obtain a  
22 clear understanding of the views held by those making  
23 submissions. So we are offering a few suggestions as a  
24 guide as to how the submissions might be prepared. We do  
25 not want it presumed that we are telling anyone how he or  
26 she should prepare his submission or how it should be  
27 presented. But we feel that those making submissions like  
28 ourselves have a common interest: to make available to the  
29 Commission and to the public at large the best possible  
30 information available on the problem of health and what







1 can be done about it, and in a simple and clear manner  
2 which can be generally understood.

3 Those preparing submissions may wish to  
4 consider the following points:

5 1. Briefs should deal with subject matters  
6 which fall within the scope of the inquiry of the Commis-  
7 sion, as contained in Order in Council P.C. 1961-883.  
8 This Order in Council and other relevant material made  
9 available by the Commission should be carefully read before  
10 briefs are prepared.

11 2. Factual information should be included  
12 to substantiate the conclusions put forward, the views  
13 expressed, the claims made.

14 3. Recommendations made should be as speci-  
15 fic as possible, putting forward concrete proposals indi-  
16 cating whether and what action should be taken, what form  
17 the action should take and how the proposal would work in  
18 practice, the estimated costs of such recommendations and  
19 the methods of financing, and the results expected.

20 4. Recommendations should, where possible,  
21 follow the specific points covered in paragraphs (a) to  
22 (1) of the Order in Council P.C. 1961-883. Where recommen-  
23 dations are against proposals made by others or do not  
24 involve action to be taken, the reasons for such recommen-  
25 dations should be given and the evidence in support of the  
26 views expressed should be spelled out.

27 5. The briefs should be prefaced by a  
28 summary containing the main conclusions and recommendations.

29 6. Brevity is recommended in the main body  
30 of the submission. Those preparing briefs should feel free







1 to submit all relevant evidence in appendix form.

2 7. In the case of associations and organiza-  
3 tions, the briefs should include information on the objec-  
4 tives and the membership of the group.

5 We require that written submissions should  
6 reach the Secretary of our Commission, Major Lafrance, not  
7 later than 15 days prior to the date of the hearing to be  
8 held in the province where the participant is located, and  
9 that is so that the Commissioners may have an opportunity  
10 to read those briefs before the hearing at the particular  
11 place. Details as to the number of copies required, the  
12 format of submissions, etc., are contained in a memorandum  
13 entitled "Guide re Submissions of Briefs and Participation  
14 in Hearings". Copies of this memorandum can be obtained  
15 on request from the Secretary of this Commission.

16 7. Preliminary Hearing

17 I come back now to today's hearing.

18 We are looking forward to receiving on this  
19 occasion observations from various governments and organiza-  
20 tions with respect to principles which may guide this  
21 Commission in its inquiry and deliberations. We would  
22 also hope to obtain suggestions of areas and problems to  
23 be covered in line with the Terms of Reference of this  
24 Commission.

25 This is the time for provincial governments  
26 and municipal authorities, the professional organizations  
27 and the public at large, to let us have their views as to  
28 what we should be covering in our investigations and  
29 research studies. We do not want to overlook a single  
30 important factor that concerns the health of the Canadian





1 people whether it is a medical, social, educational, econo-  
2 mic, financial, or legal aspect. The time to present us  
3 with your ideas is now and not when we have completed our  
4 public hearings and have prepared our report.

5 We have not asked for written submissions  
6 for this preliminary hearing though we are prepared to  
7 accept them. The procedure we are following today is to  
8 call different parties who wish to be heard and have them  
9 express their full views orally and those views will be  
10 recorded.

11 I would like to conclude these remarks by  
12 assuring you that my fellow Commissioners and I will do  
13 our best to bring to light all the basic facts, to obtain  
14 competent professional advice, to hear all the relevant  
15 views and constructive proposals made, and to come forward  
16 with recommendations which may be helpful in preserving  
17 and enhancing the health of this and future generations  
18 of Canadians.

19 To achieve this objective we require, and  
20 we hope to obtain, the full co-operation of all organiza-  
21 tions and groups concerned with health matters, the provin-  
22 cial and municipal governments and the general public.

23 And with that I now declare the preliminary  
24 hearing of the Royal Commission on Health Services as  
25 officially open.

26 I would like to mention for the information  
27 of those who may wish to obtain copies of the proceedings  
28 that the firm of Angus Stonehouse and Company, whose  
29 representatives are here, has been given the contract for  
30 court reporting services for the transcript of the







1 Commission, and that anyone wishing to secure a transcript  
2 should contact one of the reporters here present.

3 I mention too, that there is a simultaneous  
4 translation of the proceedings here today.

5 Now, in accordance with the program as I  
6 outlined it, I am now going to invite those wishing to  
7 make statements or representations to do so in the  
8 following order: first, representatives of Provincial  
9 Governments, and arbitrarily we are going to start from  
10 the east and go to the west. Followed then by representa-  
11 tives from municipalities, cities, towns, and in reverse  
12 order, from west to east. Then the Secretary will call  
13 out the names of organizations and of individuals who  
14 have said that they wish to make statements in the order  
15 that the request was received by our Secretary. We appre-  
16 ciate that there well may be others present who wish to  
17 be heard, and who have not signified their intention up  
18 to this time, and so we ask that all such, that they will  
19 please register with the Secretary at an adjournment which  
20 we will be calling about 11 o'clock, or during the noon  
21 adjournment, and those registering will be called upon  
22 in the order in which the registration is effected here  
23 today.

24 Later in the hearings, on the assumption  
25 that some who wish to make representations may not be in  
26 the hall at the moment, those will be given an opportunity  
27 to have their say.

28 So, we have now arrived at that point where  
29 the Commission is ready to receive any statements or  
30 representations from Provincial Governments, and starting





1 from east to west, I would ask if there is anyone here  
2 representing the Province of Newfoundland?

3 DR. J. McGRATH: Mr. Chairman, I am from the  
4 Province of Newfoundland.

5 THE CHAIRMAN: Thank you very much, Dr.  
6 McGrath, the Minister of Health of Newfoundland.

7 The Province of Nova Scotia?

8 MR. R. DONAHOE: R.A. Donahoe, Minister of  
9 Health for Nova Scotia. Like my colleague from St. John's,  
10 Newfoundland, I came here to listen. I have no submission  
11 to make but would like to reserve the right to be heard  
12 at some future time.

13 THE CHAIRMAN: The Province of Prince Edward  
14 Island? The Province of New Brunswick?

15 DR. J.A. MELANSON: Dr. Melanson, Chief  
16 Medical Officer. We are not prepared to make any state-  
17 ment this morning.

18 THE CHAIRMAN: I am very happy to see you,  
19 Dr. Melanson.

20 DR. MELANSON: Thank you.

21 THE CHAIRMAN: The Province of Quebec?

22 MR. S. ANDRÉ: Sylvio André, representing  
23 the French-Canadian Association for the Blind.

24

25

26 -

27

28

29 -

30







1 LE PRESIDENT: Y a-t-il ici un ou des re-  
2 présentants de la province de Quebec?

3 J'ai reçu deux lettres de l'honorable M.  
4 Lesage, premier ministre de la province de Quebec,  
5 et je demanderais donc a notre secretaire, le major  
6 Lafrance, d'en faire la lecture pour fins du compte  
7 rendu.

8 LE SECRETAIRE: Je vais lire la premiere lettre  
9 datee du 25 aout<sup>^</sup>, adressee a l'honorable Emmett M. Hall,  
10 president de la Commission;

11 " 25 aout 1961

12 L'honorable Emmett M. Hall

13 Président

14 Commission royale sur les Services de Santé

15 Edifice Daly

16 Case postale 1173

17 OTTAWA, Ont.

18 Monsieur le juge,

19 Votre lettre du 13 juillet et les pièces  
20 incluses ont fait l'objet d'une étude attentive de  
21 la part du gouvernement de la province de Québec.

22 Nous en sommes venus à la conclusion que  
23 l'enquête<sup>^</sup> que l'on veut faire porte essentiellement  
24 sur des matières du ressort exclusif des provinces.

25 Nous devons nier énergiquement au gouverne-  
26 ment fédéral le droit d'instituer une telle enquête<sup>^</sup>.

27 Sans méconnaître les différences importantes qui  
28 existent entre la constitution australienne et la  
29 nôtre<sup>^</sup>, l'arrêt du Conseil privé dans l'affaire

30 "Colonial Sugar" (1914 A.C. 237) nous paraît établir





1 le principe qu'un gouvernement ne peut entreprendre  
2 d'enquête sur des matières qui ne sont pas de sa  
3 compétence.

4 A la conférence de juillet 1960, je me suis  
5 efforcé d'expliquer clairement les raisons pour  
6 lesquelles la province de Québec, tout en prenant les  
7 mesures nécessaires pour toucher - sur une base  
8 temporaire et en préservant sa pleine souveraineté -  
9 toutes les subventions conditionnelles fédérales,  
10 réclamait la suppression du régime des subventions  
11 conditionnelles et des programmes conjoints. Nous ne  
12 pouvons donc pas admettre que l'on recherche l'expansion  
13 de ce régime au lieu de sa suppression.

14 Ce qui précède ne signifie absolument pas  
15 que le gouvernement québécois ne se préoccupe pas sans  
16 cesse de progresser dans le domaine vital qu'est celui  
17 de la santé publique, à condition que les moyens  
18 d'y arriver respectent scrupuleusement son autonomie.

19 Veuillez agréer l'expression de mes  
20 sentiments les meilleurs.

21 LE SECRETAIRE: La deuxième lettre adressée à  
22 l'honorable Emmett M. Hall est datée du 1er Septembre  
23 1961 et se lit ainsi:

24  
25 J'ai bien reçu votre lettre du 25 août qui a  
26 certes dû croiser la mienne que je vous adressais le  
27 même jour.

28 Je n'ai pas d'autres observations à vous  
29 faire que celles que contient ma lettre du 25 août à  
30 savoir, que l'enquête que l'on veut faire porte







1 essentiellement sur des matières du ressort exclusif des  
2 provinces.

3 Pour des raisons clairement expliquées dans  
4 ma dernière communication, notre attitude sur le  
5 sujet reste la même.

6 Veuillez croire toujours, monsieur le Juge, à  
7 l'assurance de mes sentiments les meilleurs.

8 LE PRESIDENT: Merci, M. Lafrance. Ces  
9 lettres expriment les vues du gouvernement de la  
10 Province de Québec. Les Commissaires et moi-même  
11 agissons selon les pouvoirs conférés par le décret  
12 du Gouverneur en Conseil que j'ai remis au Secrétaire  
13 de la Commission. Notre Commission exige que cette  
14 enquête soit faite tel que stipulé dans le décret,  
15 cependant je voudrais insister sur le fait que ce  
16 décret reconnaît expressément le rôle des provinces en  
17 ce qui a trait aux questions de santé. Dans  
18 l'accomplissement de la tâche qui nous est confiée  
19 nous tiendrons constamment compte du rôle qui appartient  
20 aux provinces et agirons donc en conséquence.

21 THE CHAIRMAN: Who is here representing the  
22 Province of Ontario?

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1 THE CHAIRMAN: Anyone here representing  
2 the Province of Ontario?

3 DR. DYMOND: I am Dr. M.B. Dymond, Minister  
4 of Health. Like my colleagues in the other provinces,  
5 we have nothing to submit this morning.

6 THE CHAIRMAN: Thank you Dr. Dymond.  
7 Province of Manitoba?

8 MR. MAURO: Mr. Chairman, A.V. Mauro,  
9 counsel for the Province of Manitoba.

10 Mr. M. Elliot, Deputy Minister of Health is  
11 also here representing the Province of Manitoba.

12 In your letter to the Premier of Manitoba  
13 dated August 25th, 1961, and again here this morning,  
14 you stated as follows:

15 "In particular we would find it  
16 very helpful to obtain an expression  
17 of views from provincial governments  
18 as to federal-provincial co-operation  
19 in the health field presently in  
20 existence and specific proposals in  
21 improving the existing system, the  
22 method by which it could be achieved,  
23 the financing involved, the  
24 administration concerned and related  
25 matters."

26 Our reply to this request will, of course, be  
27 contained in our major submission during the regional  
28 hearings in Winnipeg, and if necessary by subsequent  
29 submissions in Ottawa. We feel however, that we  
30 should at this time outline in general terms our







1 interpretation of the terms of reference and the scope  
2 of our submission.

3 Firstly, since the constitutional validity  
4 of this inquiry has been raised, some comment is in  
5 order. It is clear that pursuant to Section 92, Sub-  
6 section 7 of the British North America Act "The  
7 establishment, maintenance and management of hospitals,  
8 asylums, charities and eleemosynary institutions in  
9 and for the provinces...." are within the exclusive  
10 jurisdiction of the provincial legislatures.

11 While the Act of 1867 sets out clear divisions  
12 of authority and responsibilities as between the federal  
13 and provincial legislatures, it has become essential  
14 with the growth and development of the Canadian nation  
15 that various problems falling within the absolute  
16 jurisdiction of one or the other level of government  
17 receive the cooperation and attention of both federal  
18 and provincial authorities in order that the common  
19 good be achieved. In other words while the administration  
20 or application of particular measures comes within the  
21 exclusive powers as set out in the Act; the purpose of  
22 such measures may well be such as to require the  
23 participation and interest of all levels of government.

24 Under Section 118 of the B.N.A. Act and  
25 amendments, the federal government is permitted and has,  
26 in fact, paid substantial sums to the provinces in the  
27 form of unconditional subsidies which could be  
28 expended by the provinces at their discretion.

29 In addition to such unconditional payments,  
30 the federal government has since 1913 made conditional





1  
2 grants-in-aid for such provincial undertakings as  
3 public health, highways, technical education and  
4 agriculture. We would refer to such legislation as:

5 The Agricultural Act, Chapter 5, 1913

6 The Employment Offices Co-ordination Act,  
7 Chapter 21, 1918

8 The Canada Highways Act, Chapter 54, 1919

9 The Technical Education Act, Chapter 73, 1919

10 The Vocational Education Act, Chapter 59, 1931

11 The Canadian Farm Loan Act, Chapter 43, 1927

12 The Home Improvement Loan Guarantee Act,  
13 Chapter 11, 1937

14 The Unemployment Relief Act, 1930

15 The Unemployment and Farm Relief Act,  
16 Chapter 58, 1931

17 and more recently, the Hospital Insurance and Diagnostic  
18 Services Act, 1957. This latter Act, the provisions  
19 of which have been agreed to by all ten provinces of  
20 Canada, points out that although the prime responsibility  
21 for health services lies within the jurisdiction of the  
22 province, a full comprehensive health care plan for all  
23 Canadians must, of necessity, involve federal  
24 participation in order to effect equitable distribution  
25 of costs and to ensure the highest degree of uniformity  
26 consistent with provincial policies. There can be  
27 no doubt that measures within the exclusive jurisdiction  
28 of the provinces may affect the national interest to  
29 such a degree that it justifies, in law as in practice,  
30 federal concern and contribution.







1                   There can be little question as to the federal  
2 authorities' right to investigate the general health  
3 field of the Canadian nation. The Province of Manitoba  
4 further submits that the federal authorities have not  
5 only a right but a duty to see that there is available  
6 for all Canadians regardless of geographic location a  
7 basic standard of health care.

8                   In so doing the Province of Manitoba is in no  
9 way surrendering its rights as set out in the B.N.A.  
10 Act. The Province of Manitoba will however, suggest  
11 that where necessary, the federal authorities assist the  
12 provinces by making available the requisite revenues,  
13 to assist in achieving this basic standard of health  
14 which is the right of every Canadian citizen.

15                   It is our opinion that federal participation  
16 is essential in achieving any comprehensive health plan.  
17 With this in mind we submit that this commission should  
18 examine the feasibility of cost sharing as applicable to  
19 specific health programs presently financed entirely  
20 by the provinces. We refer to programs such as the  
21 care of the mentally ill, the care of tuberculosis,  
22 the long term care of chronic illness, administration  
23 costs, home care programs, etc.

24                   The Province of Manitoba feels that as a  
25 prerequisite this commission investigate the operation  
26 and financing of programs presently in existence before  
27 embarking on any expanded programs which would entail  
28 additional financial responsibilities for the provinces.  
29 The commission should determine the total costs involved  
30 in any of the recommended plans; the impact of these





1 costs on the nation as a whole, in relation to the  
2 national income and the extent to which these costs  
3 should be met from private as opposed to public funds.

4 I might say Mr. Chairman that this is very  
5 important, I suggest, to the provinces because in most  
6 of these schemes it is on a participation basis. Either  
7 way, there are matching grants and indeed the proposal  
8 coming forward from this commission and adopted as  
9 legislation by the federal authority could in effect  
10 bind the provinces by entering into it to incur  
11 large expenditures of revenue and we in the Province of  
12 Manitoba as of now are utilizing in excess of 98 per  
13 cent of these funds through federal grants and we  
14 believe this to be about the highest level in the  
15 Dominion of Canada and we are very concerned about any  
16 scheme that will compel us to an additional outlay  
17 without very definite research and investigation into  
18 the full operation of the present schemes.

19 The Province of Manitoba submits that your  
20 investigation should include a study of the means for  
21 providing the personnel for any comprehensive health  
22 service program. Coupled with this is the increasing  
23 problem of training facilities for health personnel  
24 and the impact of prepaid plans on such problems.

25 In our opinion, the ultimate success of any  
26 health plan is dependent upon adequately qualified  
27 personnel.

28 We submit that this commission should  
29 investigate the need for providing drugs in any  
30 comprehensive health scheme and make recommendations







1 as to how these costs can be better controlled and  
2 included in a prepaid service plan. We submit that  
3 your study must also encompass the role of para-medical  
4 services such as physiotherapy, nursing, etc. in any  
5 such a plan.

6 Measures to prevent disease and disability  
7 could reduce the incidence of the miseries and  
8 discomforts of illness and the demands upon  
9 institutional facilities; thereby reducing the present  
10 financial burden. Such preventative acts could extend  
11 the useful life of our citizens and increase the  
12 productive resources of the nation..

13 The Province of Manitoba is going to place  
14 particular emphasis on this particular point, Mr.  
15 Chairman and members of the commission, because we feel  
16 that this preventative field requires a great deal of  
17 research and it is an area where perhaps the greatest  
18 returns are possible.

19 Development of facilities for care alternative  
20 to hospital care might reduce the heavy demand for  
21 extremely expensive hospital treatment, and at the same  
22 time provide more suitable conditions for the  
23 chronically ill and the elderly. Manitoba commends to  
24 your attention this aspect.

25 The Province of Manitoba will place particular  
26 emphasis on the present financing arrangements with  
27 reference to the various formulae under which the National  
28 Health Grants are distributed. It is our opinion that  
29 there must be a more equitable sharing of capital  
30 costs in the field of hospital construction.





1 In short, Mr. Chairman, the Province of  
2 Manitoba submits that the terms of reference have been  
3 made deliberately broad and it is the intention of  
4 the Province of Manitoba to deal with the whole matter  
5 of health services, both those that are acute and  
6 require immediate attention, and those that are chronic  
7 and require long term planning.

8 I thank you very much Mr. Chairman.

9 THE CHAIRMAN: Thank you Mr. Mauro.

10 Province of Saskatchewan?

11 DR. MATHEWS: The Province of Saskatchewan  
12 would like to assure this Commission of its full  
13 cooperation in its work. Although extremely interested  
14 in the work of the Commission, the province has no  
15 submission at the present time.

16 THE CHAIRMAN: Thank you Dr. Mathews.

17 Province of Alberta?

18 Very nice to see you Mr. Frawley.

19 MR. FRAWLEY: Thank you Mr. Chairman. I  
20 have a short statement to make on behalf of the  
21 Government of the Province of Alberta. The Government  
22 of Alberta will make a submission to the Commission  
23 when they sit in Edmonton in February next.

24 I will go much more slowly than I ordinarily  
25 go, Mr. Chairman because I am mindful of the fact  
26 there is simultaneous translation.

27 I have no instructions as to what the nature  
28 of the submission of the Alberta government will be  
29 but I know that I can assure the Commission that  
30 the representations will be worthwhile. Our province







1 has what I think I can call a very creditable health  
2 and welfare program and I am sure that the knowledge  
3 and experience gained in the administration of those  
4 programs will mean informatitive representations  
5 concerning the important matters which have been  
6 referred to you by the Governor-General-in-Council  
7 for investigation and report.

8           However, Mr. Chairman, I do have instructions  
9 upon a particular aspect and I would like to deal just  
10 briefly with that.

11           The opening paragraph of P.C. 1961-883  
12 recites the report to the Privy Council of the Right-  
13 Honourable the Prime Minister which submitted that  
14 it was considered to be in the public interest to have  
15 a study made "of the needs of the Canadian people  
16 for health services".

17           The Terms of Reference do not spell out a  
18 precise definition of "health services" but I am sure  
19 that no one would argue that they do not extend to  
20 the prescribing and supplying of drugs to the people  
21 of Canada.

22           Paragraph (a) of the Terms of Reference  
23 directs an inquiry into and a report upon "the  
24 existing facilities and methods for providing personal  
25 health services including prevention, diagnosis,  
26 treatment and rehabilitation."

27           Clearly, in my view, the view of my  
28 principals all aspects of drug therapy are within the  
29 ambit of that paragraph. I make it clear Mr.  
30 Chairman that at this time I only seek from the





1 Commission at this preliminary stage a ruling or  
2 an understanding that representations, submissions  
3 and recommendations upon the very important question  
4 of the burden of the cost of drugs upon the people  
5 of my province will not be rejected or excluded.

6 I do not wish to, and indeed I am unable to  
7 anticipate what will be our submission upon the  
8 burden of the cost of drugs and how to deal with it.

9 I merely ask a ruling from the Commission  
10 so as to avoid the unfortunate eventuality that  
11 after spending time and incurring expense to present  
12 views upon the drug segment of health services, our  
13 efforts would be thrown away and be regrettably  
14 wasted by a ruling that the Commission did not regard  
15 the Terms of Reference as covering drugs, their  
16 prescription, their supply and their cost.

17 In Alberta we now have two drug supply  
18 programs and another one under consideration. The  
19 programs are the Rheumatic Fever Prophylactics program  
20 which involves the supply of penicilin G and the dia-  
21 betic tolbutamide program which involves the supply  
22 of the drug called tolbutamide. The third program  
23 to which I referred is one involving the supply of the  
24 very relatively expensive drugs, steroids, cortisone  
25 derivatives.

26 I only bring that to your attention sir to  
27 indicate those drugs are purchased in large quantities  
28 by the province. The penicilin G is now purchased  
29 in 200,000 tablet quantities at three cents and the  
30 ordinary prescription price is 19 $\frac{1}{4}$  cents.







1           The talbutamide is purchased by the province  
2   for 4 and 3/5th cents each and the price sold on  
3   prescription is 14 cents each. Now I only bring that  
4   to your attention as indicating the kind of program  
5   that is there. I suppose it is quite unnecessary to  
6   add these drugs are only supplied to people who are  
7   without means to otherwise buy them or upon whom  
8   the debt cost would be a burden.





dpw

1 Now, it may be said, sir, that there is at  
2 the moment an inquiry into the cost of drugs by the  
3 Restrictive Trade Practices Commission, and it might be  
4 said that that inquiry should suffice. Indeed, sir, that  
5 inquiry is of a quite different nature and subject to  
6 many restrictions which do not apply to this Commission  
7 operating under the Terms of Reference given to this  
8 Commission by the Governor-General in Council.

9 The Department of Justice conducted a preli-  
10 minary inquiry into the manufacture, distribution and  
11 sale of drugs. I only want to read one sentence from the  
12 preface to that report merely to emphasise the point I  
13 am making, namely, the limited character of that inquiry.  
14 I read from the preface:

15 "The Inquiry has not been concerned with the  
16 level of prices as such or whether prices are reasonable.  
17 Rather, the Statute contemplates the inquiry has been  
18 concerned with the question of whether the prices of drugs  
19 in Canada are the result of conditions or practices  
20 related to monopolistic situations or restraint of trade."

21 The position I am taking, sir, then, is that  
22 as plainly appears from the Commission's own words the  
23 Restrictive Trade Practices Commission is not concerned  
24 and cannot be concerned, because it is guided by the  
25 provisions, of course, of the Combines Investigation Act,  
26 with the level of prices as such or whether prices are  
27 reasonable. The question therefore arises in the minds  
28 of my principals, sir, is: How will this Commission, under its  
29 directive to investigate the needs of the health of the  
30 people of Canada, investigate the allegedly - I underline







1 the word allegedly - high cost of drugs and recommend  
2 ways and means of bringing about a reduction in such cost?  
3 The matter is unquestionably a proper matter for Federal  
4 investigation, because we find, sir, that the principal  
5 statute governing the distribution and supply of drugs in  
6 Canada is a Federal Statute, the Food and Drugs Act. And  
7 speaking just offhand, I do not know that the constitutio-  
8 nality of that statute has ever been questioned.

9 I point out merely by way of signposts some  
10 of the matters this Commission might find it useful to  
11 inquire into. I would suggest investigation of the pros  
12 and cons, and I purposely say the pros and cons, of the  
13 use of generic names rather than brand names in the  
14 prescribing and supply of drugs. That is again definitely  
15 in my view a Federal aspect. An examination of the price  
16 spreads, of the spread between the cost to the manufacturer  
17 and the two important sale prices, namely, the sale to  
18 government institutions of the kind I have indicated - and  
19 I only give them as an indication - the spread therefore  
20 between the cost to the manufacturer and the sale price to  
21 governments and hospitals and the sale to the patient with  
22 prescription and at the retail pharmacy.

23 I merely put the question as a subject within  
24 the range of your inquiry. Are these spreads too great  
25 or on the contrary are they quite justified? Is unneces-  
26 sary product promotion a significant factor in the cost  
27 of drugs? Can it be controlled, with benefit to the price  
28 to the patient and without detriment to the industry?

29 Again I say these things to you, sir, as  
30 merely indicating something which in my respectful





1 submission is not only quite within the terms of your  
2 reference but which in my submission would be a proper  
3 and fruitful and beneficial field for you to cultivate.  
4 I do not wish these enumerations to be more than just  
5 indications of your possible range of inquiry.

6 My principals would be glad to have your  
7 ruling on what we regard as this important aspect at your  
8 convenience and having in mind that the preparation of  
9 Alberta's submission is, I understand, sir, already under  
10 way.

11 I think, sir, that is all I have to say.  
12 Thank you.

13 THE CHAIRMAN: Mr. Frawley, before you leave,  
14 I think I am prepared now on behalf of the Commission to  
15 assure you and the Province of Alberta that submissions  
16 as to the matters you have mentioned will be received by  
17 the Commission.

18 MR. FRAWLEY: I am very pleased.

19 THE CHAIRMAN: There will be no limitations  
20 on the subject matter of the Terms of Reference which will  
21 be excluded.

22 MR. FRAWLEY: Thank you very much, sir.

23 THE CHAIRMAN: Province of British Columbia.  
24 Anyone here to represent the Province of British Columbia?

25 Then we proceed to hearing submissions or  
26 representations on behalf of municipal governments,  
27 starting from west to east, but because we meet in Ottawa  
28 we give Ottawa preference this morning. If there is some-  
29 one here on behalf of the City of Ottawa we shall be glad  
30 to hear from them now.







1                   Anyone representing or speaking for a municipi-  
2 pal government at whatever level from the Province of  
3 British Columbia?

4                   The Province of Alberta?

5                   The Province of Saskatchewan?

6                   The Province of Manitoba?

7                   The Province of Ontario?

8                   The Province of Quebec?

9                   New Brunswick?

10                  Prince Edward Island?

11                  Nova Scotia?

12                  Or Newfoundland?

13                  I expect that we will be receiving represen-  
14 tations from municipal governments in the hearings in the  
15 provinces, because we have had indications to that effect  
16 in the correspondence.

17                  Then, Mr. Secretary, we will hear from those  
18 who have indicated that they wish to be heard in the order  
19 as you have listed them, which, as I said before, is the  
20 order in which we heard from these parties following our  
21 first publication. Mr. Lafrance?

22                  THE SECRETARY: Could we call on the  
23 Canadian Psychiatric Association to come forward first?

24                  DR. SAUCIER: I am Dr. Saucier, President of  
25 the Canadian Psychiatric Association.

26                  THE CHAIRMAN: We are pleased to have you  
27 here, Dr. Saucier.

28                  DR. SAUCIER: Thank you.

29                  The Canadian Psychiatric Association is a  
30 national incorporated society of medical specialists in





1 the mental health field. The Association represents 635  
2 psychiatrists and has affiliated societies in every  
3 province excepting Prince Edward Island. The national  
4 Association is affiliated with the Canadian Medical Asso-  
5 ciation; each provincial society maintains close relation-  
6 ship with its provincial medical association.

7           The membership of the Canadian Psychiatric  
8 Association covers the whole range of psychiatric experience  
9 - private practice, community clinic work, general hospital  
10 in-patient and out-patient services, mental hospital  
11 services, undergraduate and graduate medical education and  
12 research enquiries, both clinical and laboratory. The  
13 Association, therefore, has intimate involvement in the  
14 problems of mental health.

15           The problem area of greatest concern to the  
16 Association is the continuance of segregation attitudes  
17 towards the mentally ill on the part of political and  
18 health authorities. The Canadian mental hospitals, out-  
19 moded organizationally and functionally, house 70,000  
20 patients. Insufficient funds, rigid patterns of admini-  
21 stration and insufficient incentives to personnel deter-  
22 mine an inadequate standard of care.

23           In general, the Association considers that  
24 the services for the mentally ill should be developed on  
25 the same basis as other health services; in particular,  
26 the Association envisages closer relationships with  
27 general hospital arrangements, including coverage by  
28 hospital insurance and appropriate professional re-imburse-  
29 ment and encouragement.

30           The Canadian Psychiatric Association will be







1 presenting a more comprehensive brief at an appropriate  
2 time in the Commission's proceedings. Other concerns  
3 will be raised then (e.g., services for emotionally  
4 disturbed children, the mentally retarded, the aged, for  
5 supporting psychiatric centres for education and research).  
6 The present communication introduces the interest and  
7 responsibility of the Association in the mental health  
8 field.

9 That is all I have to say.

10 THE CHAIRMAN: Thank you, Dr. Saucier.

11  
12 --- A Short Recess.

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1 THE CHAIRMAN: Are we ready to come to  
2 order ladies and gentlemen?

3 THE SECRETARY: Will the Canadian Welfare  
4 Council please come forward.

5 THE CHAIRMAN: The Canadian Welfare Council.

6 DR. G.M. HOUGHAM: Sir, we have presented a  
7 preliminary submission advance. I just wanted to say  
8 that we are prepared to have it taken as read. If  
9 you prefer us to read it, it is fairly brief, and  
10 we are prepared to do so.

11 THE CHAIRMAN: I think it would be desirable  
12 for you to read it, if you will do so.

13 DR. HOUGHAM: Mr. Chairman and Commissioners:  
14 Introduction

15 The Canadian Welfare Council is a voluntary  
16 association of public and private agencies and of citizen  
17 groups and individuals interested in policies and programs  
18 which affect individual well-being and social welfare  
19 in Canada. Its objective is to help ensure for the  
20 people of Canada social security measures and social  
21 services that are adequate in extent, of high quality  
22 and soundly administered.

23 The Royal Commission on Health Services has  
24 a unique opportunity to contribute significantly to  
25 the furtherance of this objective. The Council welcomes  
26 the appointment of this Commission and, within the  
27 limits of its competence and resources, is ready to  
28 assist the Commission in any way possible in its  
29 important and challenging assignment.

30 The Council plans to make a submission to







1 the Commission at a later date and a special Council  
2 committee was recently appointed to assist in this  
3 undertaking.

4 In response to the Commission's invitation,  
5 the special Council committee here presents the results  
6 of its initial thinking concerning principles which,  
7 the Committee believes, should guide the Commission in  
8 its deliberations and concerning areas and problems  
9 to which, in its view, the Commission should give  
10 particular attention.

#### 11 Guiding Principles

12 1. The ultimate purpose of all health and  
13 welfare services is to help people. In the planning,  
14 provision and administration of these services,  
15 preservation of the interests and dignity of the  
16 individual should be of paramount concern.

17 2. The physical and mental health of the individual  
18 and his social well-being are so closely interwoven as  
19 to be indivisible. The broad range of health and  
20 welfare services which he may need must therefore be  
21 closely integrated and fully co-ordinated.

22 3. Although our overall objective should be to  
23 ensure that health and welfare services of the highest  
24 quality are available to all Canadians, practical  
25 considerations will probably require the setting of  
26 priorities and the implementation of the national program  
27 by stages.

28 A realistic and responsible rating of priorities  
29 demands informed judgment. In its preliminary work,  
30 the Council's committee has already identified two areas





1 where further deliberation and fact-finding are  
2 required as a basis for such judgment. They are the  
3 following:

- 4 a) Although Canada's overall health  
5 record is usually regarded as  
6 comparatively high, the level of health  
7 in some areas and by some indices is  
8 unsatisfactory. We need a critical re-  
9 examination of the indices applied in  
10 measuring the nation's health level  
11 and the formulation of more effective  
12 standards by which past performance  
13 can be assessed and future progress  
14 determined.
- 15 b) Financial considerations inevitably  
16 loom large in the weighing of priorities.  
17 In order to establish priorities in  
18 the further development of health services,  
19 we need uniform procedures for the  
20 costing of all health personnel and  
21 services and the accumulation of  
22 comparable cost data based on these  
23 procedures.

24 4. The fourth principle: for the individual or  
25 family, illness not only poses the threat of a large  
26 and unpredictable financial burden, but may also  
27 diminish or disrupt earning power. In its policy  
28 statement on social security, the Council is already  
29 on record in support of an illness income protection  
30 program. In the event that the Commission gives







1 consideration to this important matter, the Council  
2 believes that it should be assessed in the broader  
3 context of the interdependence of all components in  
4 Canada's total social security system.

5 Areas and Problems Requiring Particular Attention

6 A. Health Care Planning

7 1. Health care involves a complex  
8 network of health and welfare relationships  
9 and services. It is essential that we  
10 have adequate machinery and trained  
11 personnel for the identification and  
12 measurement of changing needs, for the  
13 setting and periodic review of priorities,  
14 for the planned development and continuous  
15 co-ordination of the full range of public  
16 and voluntary health and welfare services  
17 which are required, and for the conduct  
18 of essential program research, service  
19 experiments and demonstration projects.

20 2. The human service professions and their  
21 patients or clients have a shared interest  
22 in standards of treatment and quality of  
23 care. In the protection and improvement  
24 of quality, the formulation of objective  
25 standards and the maintenance of adequate  
26 control procedures is a continuing need and  
27 problem.

28 B. Health Care Services

29 1. Range of Services: In the planning  
30 and provision of improved health services,





1 an even and balanced development is in  
2 the interest alike of the patient, the  
3 professions and the community. Adequate  
4 diagnostic and acute treatment services  
5 and facilities are essential. Equal  
6 attention must be given to the vital role  
7 of nursing homes, chronic and convalescent  
8 care facilities, out-patient services,  
9 home care programs, community health  
10 clinics and the like; to the important  
11 contribution of auxiliary services such  
12 as homemakers, medical social work and  
13 rehabilitation programs; and to the  
14 significance of such health care requirements  
15 as nursing service, drugs and special  
16 diets, and appliances.

17 2. Distribution of Services: Improved  
18 health care for all Canadians requires  
19 not only a balanced development of services  
20 and facilities, but also their more rational  
21 distribution. Given Canada's wide regional  
22 and urban-rural variations in population,  
23 economic strength and community resources,  
24 the uneven distribution of health personnel  
25 and facilities is already a difficult and  
26 pressing problem.

27 3. Manning of Services: Provision of  
28 the best in modern health care depends on  
29 the knowledge and skills of a varied and  
30 specialized team of medical and related







1 health and welfare personnel. With  
2 qualified personnel already in short  
3 supply, there is a growing need for study  
4 and experiment in methods of professional  
5 and technical recruitment, training,  
6 deployment and remuneration, as well as in  
7 procedures for the maintenance and improvement  
8 of professional standards in training and  
9 treatment.

10 C. Cost of Services

11 The spiralling costs of good health care in  
12 recent decades is too familiar to require elaboration  
13 or emphasis. The growing financial burden imposed  
14 by illness makes more difficult and, at the same time,  
15 more urgent the problem of ensuring that health services  
16 are available to everyone, without regard to individual  
17 or family income, age, place of residence or other  
18 extraneous considerations.

19 D. The Importance of the Individual

20 As implied in the first principle that I have  
21 already enunciated, <sup>emphasis in</sup> both health and welfare services  
22 should be on the personal treatment of the individual  
23 rather than the impersonal treatment of "cases".

24 The practical implications of this point are  
25 fundamental to good health care. We must seek more  
26 effective machinery for citizen involvement in the  
27 planning of health services and programs. The  
28 individual's right of choice in health personnel and  
29 facilities must be protected and adequate machinery  
30 must be provided for the airing of complaints and





1 hearing of appeals. Finally the physical facilities  
2 and professional attitudes should afford a climate  
3 in which respect for the individual is obviously a dominant  
4 influence.

5 Thank you, Mr. Chairman.

6 THE CHAIRMAN: Thank you Dr. Hougham.

7 THE SECRETARY: The Canadian Arthritis  
8 and Rheumatism Society.

9 MR. C.M. KING: Mr. Chairman and members of  
10 the Commission. My name is King and I am the President  
11 of the Executive Committee of the Canadian Arthritis  
12 and Rheumatism Society.

13 Mr. Chairman and members of the Commission:

14 The Canadian Arthritis and Rheumatism Society  
15 greatly appreciates this opportunity to present the  
16 Commission with its views as to the scope of the  
17 Commission's inquiry.

18 Arthritis and the other rheumatic diseases  
19 constitute a health problem of national importance  
20 because of their widespread incidence, and the burdens  
21 of suffering, disability, social and economic loss  
22 which they impose. The rheumatic diseases rank second  
23 only to the cardiovascular diseases among the leading  
24 causes of physical disability, as shown by the Canadian  
25 Sickness Survey of 1951.

26 Any program leading to the conquest of the  
27 rheumatic diseases must take account of two main  
28 circumstances. First: the cause, means of  
29 prevention, and specific cure for most of the common  
30 and serious forms of arthritis and rheumatism remain







1 unknown. Medical research is the prime lever by  
2 which the burden of the rheumatic diseases may be lifted  
3 from suffering mankind. Progress already made holds  
4 the promise of future success.

5 Second: the prompt and sustained application  
6 of treatment measures already known to medical science  
7 can prevent serious disability in a high proportion of  
8 patients. To achieve such results, there must be a  
9 sufficient body of well trained personnel, supported  
10 by well organized facilities.

11 In research - we ask the Commission to give  
12 careful consideration to measures which will strengthen  
13 medical research generally. We believe that specific  
14 provisions should also be made for the support of  
15 research programs which stimulate investigation of  
16 those diseases causing the greatest loss and suffering.  
17 Research is essential to the ultimate economy and  
18 immediate efficiency of health services.

19 Major discovery is not the sole objective of  
20 medical research. We ask the Commission to study  
21 the signal contribution which medical research,  
22 particularly medical research involving the clinical  
23 study of patients, can make to the improvement of  
24 methods and standards of medical care.

25 With regard to professional personnel -  
26 early diagnosis is essential to the successful  
27 treatment of rheumatic disease. Because of the vast  
28 numbers of patients involved, and the absence of mass  
29 diagnostic tests, the achievement of early diagnosis  
30 depends upon the skill and training of the general





1 practitioner. So must the treatment of the majority  
2 of patients. We therefore ask the Commission to  
3 consider the measures which will contribute to the  
4 highest standards of medical education, both graduate  
5 and undergraduate, and which will lay sufficient stress  
6 upon the management of chronic diseases. We also ask  
7 the Commission to consider measures necessary to  
8 encourage a sufficient number of young men and women,  
9 of the highest calibre, to select careers in medicine,  
10 and the essential para-medical professions.

11 Development of Facilities - The majority  
12 of rheumatic disease patients can and should be treated  
13 by their family doctors. Both patient and doctor will  
14 require access to hospital and related facilities from  
15 time to time, depending upon the patient's needs. Where  
16 diagnosis, treatment and rehabilitation present unusual  
17 difficulties, specialist personnel and specialized  
18 facilities are requested.

19 While certain special facilities are  
20 required, the Society believes that the diagnosis,  
21 treatment and rehabilitation of rheumatic disease  
22 patients should be fully integrated with facilities  
23 provided for the care of sick members of the community  
24 generally.

25 Traditionally, general hospitals have been  
26 regarded as high cost, high standard institutions for  
27 the care of the acutely ill, whereas chronic disease  
28 hospitals have been regarded as lower cost, lower  
29 standard institutions for the care of the chronically  
30 ill. The Society recognizes the importance of







1 classifying institutions and patients in a manner  
2 contributing to maximum efficiency and economy, but  
3 holds that the probable duration of illness should  
4 no longer be regarded as the primary factor to be  
5 considered when the classification is made. There  
6 are patients with chronic diseases who should be  
7 treated, for longer or shorter periods, in the high  
8 cost, high standard institutions. Equally there are  
9 patients with acute illnesses who could be cared for  
10 satisfactorily in the lower cost, lower standard  
11 institutions. The Society believes that the sharp  
12 line which has been drawn between general hospitals  
13 and chronic disease hospitals should become progressively  
14 less distinct, in a planned merging of total health  
15 resources.

16 The Society also believes that the development  
17 and use of health resources and facilities should be  
18 regionally planned. This planning should embrace not  
19 only hospitals, but also a variety of related ancillary  
20 facilities and services, including substitute homes  
21 (such as boarding homes and nursing homes), and programs  
22 to provide improved care for patients in their own homes  
23 or substitute homes. The regional organization should  
24 provide for ease of transfer of patients among its  
25 various elements, in accordance with their particular  
26 and changing needs. Its operation should be motivated  
27 by the rehabilitation approach, and it should be  
28 permeated by adequate rehabilitation resources.

29 In our view, the centre of each regional  
30 organization should be a major general hospital, directly





1 associated with peripheral hospitals, substitute  
2 homes and home care programs. The Society believes  
3 that there should be special rheumatic disease units  
4 located within the major general hospitals lying at  
5 the heart of each regional organization. The wards,  
6 laboratories, and specialist personnel of these units  
7 would provide for the classification of unusual or  
8 difficult cases. Patients should be retained in these  
9 units only so long as they cannot be efficiently  
10 treated in the other facilities forming part of the  
11 regional organization. These rheumatic disease units  
12 would exercise a beneficial influence on the standards  
13 of treatment throughout the entire regional organization,  
14 and thus lead to reduction in the incidence of permanent  
15 physical disability.

16 Extensive experience in the United Kingdom  
17 and the Scandinavian countries and limited experience  
18 in Canada, has shown the therapeutic and economic  
19 value which results from the admission to hospital, at  
20 an early stage in their illness, of those patients  
21 suffering from the more severe forms of rheumatic  
22 disease.

23 The Society urges the Commission, therefore,  
24 to give its most careful attention to measures which  
25 will ensure sound regional planning of total health  
26 resources, within which the proper attention can be  
27 paid to the requirements for the improved care of  
28 rheumatic disease patients.

29 General - While these observations, sir, have  
30 been made with the rheumatic disease problem uppermost







1 in our minds, we believe that they have relevance  
2 to other chronic illnesses and the planning and  
3 organization of health services generally.

4 Mr. Chairman, and members of the Commission:  
5 above all, The Canadian Arthritis and Rheumatism Society  
6 asks you, throughout your deliberations, to remember  
7 the needs of those tens of thousands of victims  
8 of lingering illnesses, the chronic diseases which often  
9 rob the body of its essential vitality without taking  
10 life itself, and which impose a staggering burden  
11 of suffering, social and economic loss.

12 THE CHAIRMAN: Thank you, very much Mr. King.

13 THE SECRETARY: Mr. K.O. Bardwell.

14 MR. BARDWELL: Mr. Chairman and members of  
15 the Commission. I am a private citizen. I live here  
16 in Ottawa, and I will read this statement as it has  
17 been handed to you.

18 I would like briefly to outline the main  
19 points of my intended submission so that others, who  
20 may have thoughts on the same subjects, can prepare to  
21 support or oppose my principal contention that any plan  
22 resulting from this probe should not offer lesser  
23 benefits to the general public than the plan now  
24 covering half a million who are members of the families  
25 of employees of the state itself. I intend in fact  
26 to extend this assertion to list the shortcomings of  
27 this plan, to assert that the minimum protection offered  
28 should be made substantially complete and that the  
29 statistics which are available from the operation of the  
30 Public Services Medical Plan should be accepted as





1 representative in their area, due to the large number  
2 and wide dispersal of the members of the group. There  
3 are other points I should want included to assure  
4 consideration of a wider area of health costs and I  
5 shall mention these.

6 I should mention before proceeding further  
7 that mine would be a private brief. Its submission  
8 is motivated by concern for those people who have no  
9 protection or only very partial protection against the  
10 high costs of ill health. I am aware of these costs  
11 because I have had serious and expensive illnesses in  
12 my family but I have always had group insurance to  
13 cut our cost. One cannot ignore the fact that most  
14 people here do not have anything like complete  
15 coverage and that illness spells absolute ruin to many.  
16 I shall come before you to ask that our country arrange  
17 to give everyone the same protection I enjoy, and  
18 recognizing the shortcomings of that plan, that it  
19 be extended to correct the omissions. From the foregoing  
20 you will realize that I am an employee of the Government  
21 of Canada. I work in a research division of a department  
22 which has nothing whatsoever to do with policy on  
23 health matters, thus mine is a totally insensitive  
24 position politically. My views, so far as I know, do  
25 not represent those of any organized group. I have been  
26 told that submissions to Royal Commissions by civil  
27 servants are extremely rare but I would know that I had  
28 crossed on the other side of the road if I didn't speak  
29 now.

30 I mentioned the Public Service Medical Plan as







1 a model. This group policy covers employees and  
2 dependents of the federal government, armed forces,  
3 crown agencies and boards, over half a million in all or  
4 three per cent of our population. It pays stated sums  
5 for surgical and diagnostic procedures and, after a  
6 deduction, 80 per cent of the net bill for most  
7 medical costs. It thus covers up to 80 cents on every  
8 dollar spent on drugs, ambulances, special nurses, etc.  
9 but it totally ignores dental costs other than those  
10 resulting from accidents. Since dental costs are  
11 equal to one quarter of our doctor bills for the  
12 average Canadian this is a serious omission. Again,  
13 prosthetic devices are covered, but not eyeglasses or  
14 hearing aids, even in part. I remember driving a little  
15 girl to a childrens hospital in Calgary to be measured  
16 for a new leg (at frequent intervals, as she grew)  
17 and was amazed to learn that her mother had to pay for  
18 each limb. There was no agency then to cover it, nor  
19 is there now for most.

20 We are told that your group will study the  
21 medical care plans in use in various west European  
22 countries. Many of us have high regard for the  
23 British National Health scheme. I hope you will  
24 consider it closely and not omit the allied services.  
25 The terms of reference of the Beveridge Committee  
26 which originated the recommendations upon which this  
27 great plan is based commend themselves to you. They  
28 were asked to consider the whole broad field of social  
29 insurance systems, not as some here will ask you, to  
30 consider only a small part of the problem. I hope that,





1 as they did, you will recommend a comprehensive and  
2 compulsory scheme so that none will be denied  
3 protection. It should be uniform across the country  
4 so that it will not restrict freedom of movement,  
5 and at this point I should state that freedom of  
6 movement is imperative when you have a multiplicity  
7 of plans. At this very moment I could not change  
8 employers freely, because I have good health insurance  
9 and I could not take a chance on changing jobs. I  
10 may need all that 7500 of coverage.

11 I hope that when you consider European plans  
12 you will note the effect of some of our local customs.  
13 I would like to see you report on the provision of  
14 out-patient diagnostic and treatment services, the  
15 integration of ambulance and clinical services, also  
16 dispensary service, in hospital clinics. I hope you  
17 will consider the whole area of health care and  
18 recommend the best system for each field, from wherever  
19 adopted. I hope you will consider the whole dollar  
20 of health costs, not the fractions represented by the  
21 doctor, the druggist or the dentist. I have suggested  
22 an existing minimum plan.....I hope you will not go  
23 below it in considering what to recommend.

24 To this statement I would like to add the  
25 request that you request statistics from the appropriate  
26 agency, since this plan has been in operation more than  
27 a year and, as I say, it covers more than three per  
28 cent of our population. You would have to get an  
29 authorization to get those statistics, because the  
30 system operating as it does with a huge number of







1 insurance companies, all participating and one  
2 administering, has a firm contract that it will not  
3 issue those statistics, and you will have to get  
4 statistics from the companies.

5 Thank you.

6 THE CHAIRMAN: Thank you, Mr. Bardwell.

7 THE SECRETARY: The Registered Nurses'  
8 Association of British Columbia.

9 MISS ADA GEORGE, R.N.: Mr. Chairman, and  
10 members of the Commission. I am Miss George, and I  
11 am President of the Registered Nurses' Association of  
12 British Columbia. The Registered Nurses' Association  
13 of British Columbia would be most interested, and  
14 confine their brief generally to nursing and the  
15 suggested problems for inclusion in the scope of the  
16 inquiry.

17 1. Standards of nursing care - what are the  
18 present standards, are they satisfactory, how are they  
19 maintained, are some patients being "over-nursed".

20 2. Lack of qualifications of many senior personnel  
21 in hospital services; the need for extension of  
22 provisions for adequate preparation for senior positions,  
23 supervisors and head nurses.

24 3. Clarification of the functions and  
25 responsibilities of the various professional and lay groups  
26 of personnel participating in the provision of health  
27 services.

28 4. Investigation of the need for regionalization  
29 of health services - i.e. geriatrics, rehabilitation,  
30 home care, the various specialties.





1 5. Development and coordination of various types  
2 of health services and procedures for transfer of patients  
3 from one type of service to another.

4 That is, for example, for acute care to a  
5 custodial care and to home care.

6 6. Investigation of the proportion of the cost  
7 of patient care which is in reality a cost of  
8 education of health personnel, and what effect this  
9 has on:

10 (a) apparent cost of patient care

11 (b) limitation of standards of educational  
12 programs.

13 THE CHAIRMAN: Thank you, Miss George.  
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1 THE SECRETARY: The Canadian Red Cross  
2 Society?

3 MR. STEARNS: My name is Marshal Stearns.  
4 I am past President of the Canadian Red Cross Society.  
5 Both the President and our National Commissioner are away  
6 on other Red Cross duties. I am presenting the brief  
7 submission.

8 1. The Canadian Red Cross Society was  
9 delighted to hear that the Committee of the Privy Council,  
10 on the recommendation of the Right Honourable the Prime  
11 Minister, had appointed a Royal Commission to make a  
12 comprehensive and independent study of the needs of the  
13 Canadian people for health services and the resources  
14 available to meet such needs. The eventual purpose of the  
15 study, and the recommendations to be made as a result of  
16 it, viz. "to ensure that the best possible care is  
17 available to all Canadians", can be heartily endorsed by  
18 the Canadian Red Cross Society which has worked toward the  
19 achievement of this aim since 1919.

20 2. We congratulate the Committee of the  
21 Privy Council, and the Right Honourable the Prime Minister,  
22 on the extremely high calibre of the persons who have  
23 agreed to serve on the Royal Commission and particularly  
24 on the appointment of such an eminent Chairman in the  
25 person of the Honourable Chief Justice Emmett M. Hall, Q.C.

26 3. The Canadian Red Cross Society believes  
27 deeply and sincerely in the value of citizen participation  
28 in the prosecution of health and welfare services. We  
29 believe that the voluntary agency is the logical vehicle  
30 for such citizen participation. We agree wholeheartedly





1 with the description of voluntary agencies contained in  
2 THE CANADA YEAR BOOK, 1960:

3 "A number of national voluntary agencies  
4 carry on important work in the provision of  
5 health and welfare services, planning and  
6 education. These agencies.....supplement  
7 the services of the federal and provincial  
8 authorities in many fields and play a leading  
9 role in stimulating public awareness of  
10 health and welfare needs and in promoting  
11 action to meet them".

12 4. Our Central Council proposes to submit  
13 a brief to the Commission at one of its sittings in the  
14 Province of Ontario. This brief will be in two parts, one  
15 dealing with "The Origin, Development and Future of the  
16 Canadian Red Cross Blood Transfusion Service", the other  
17 with the role of the Voluntary Agency in Health Services  
18 in general, restricting our treatment to Red Cross  
19 experience and programmes.

20 5. To save the time of the Commission and  
21 lighten its burden, our Central Council has ruled that  
22 none of our ten provincial divisions and 1,200 local  
23 branches will submit individual briefs. In order that  
24 our plans may be understood by other agencies, both  
25 official and private, and the press at the local level,  
26 we shall be grateful if the Royal Commission will be good  
27 enough to announce in each province that the views of the  
28 Canadian Red Cross Society will be presented in one brief  
29 on behalf of our Central Council at a time and place  
30 arranged by the Commission.







1 Thank you sir.

2 THE CHAIRMAN: Thank you very much Mr.  
3 Stearns. Thank you too for your kind reference to the  
4 Commissioners and myself. We may hope that at the conclu-  
5 ding hearing of the Commission somebody may say something  
6 equally kind.

7 MR. STEARNS: I am sure they will sir.

8 THE CHAIRMAN: Association of Canadian  
9 Medical Colleges?

10 DR. ETTINGER: Mr. Chairman, members of the  
11 Commission, I am Dr. Ettinger, President of the Associa-  
12 tion of Canadian Medical Colleges which represents the  
13 views of the twelve Faculties of Medicine in the Universi-  
14 ties in Canada. This Association will submit a brief at  
15 a formal meeting later, but in the meantime I wish to  
16 express the hope that the Royal Commission appoint or  
17 authorize the appointment of a panel to consider the  
18 various aspects of medical education in Canada for I  
19 believe that a report prepared by such an officially  
20 appointed group which might require the expert assistance  
21 of a statistician, would be of great help to the Royal  
22 Commission in determining its recommendations with respect  
23 to the place of medical education in the health services  
24 of Canada.

25 THE CHAIRMAN: Thank you Dr. Ettinger.

26 THE SECRETARY: The Canadian Dental Associa-  
27 tion?

28 DR. GULLETT: Mr. Chairman, members of the  
29 Commission, my name is Don W. Gullett, Secretary of the  
30 Canadian Dental Association.





1 I desire to say we welcome a study of the  
2 dental services by the Commission. Furthermore, we offer  
3 full co-operation in any feasible manner in fulfilling  
4 such objectives.

5 As you are aware, we have already submitted  
6 to you, as requested, a statement of areas, coverage and  
7 principles which we suggest to the Commission.

8 AREAS TO BE COVERED

9 Dental disease constitutes one of Canada's  
10 most serious health problems. Before measures for the  
11 alleviation and eventual solution of this problem can be  
12 recommended, the extent of unmet dental needs, the reasons  
13 for these unmet needs, and the resources available to meet  
14 them must be studied.

15 In particular, four major areas of dentistry  
16 would seem to warrant detailed examination.

17 1. Dental Needs

18 - estimates of the incidence and prevalence  
19 of dental caries, periodontal disease, and  
20 malocclusion

21 - proportion of total needs being met

22 - reasons for the discrepancy between need  
23 and effective demand for dental services

24 - estimates of accumulated needs and annual  
25 maintenance needs in terms of cost and  
26 dental man hours

27 - comparison of dental needs in areas with  
28 preventive programs (such as fluoridation,  
29 dental health education) and in areas  
30 without preventive programs







2. Dental Services

- resources of professional and auxiliary personnel
- proportion of dental health needs that resources can meet
- existing preventive, diagnostic, and treatment programs
- evaluation of the effectiveness of these programs in relation to cost and manpower expended
- effectiveness and cost of preventive programs compared with treatment programs

3. Dental Education

- existing facilities of dental schools
- plans for future expansion
- recruitment of dental students and auxiliaries
- development of training programs for auxiliaries
- financial aid to schools and students
- placement of graduates
- continuing education for graduates

4. Dental Research

- development and contributions
- current and future areas of investigation
- personnel and facilities
- amount and sources of funds

STATEMENT OF PRINCIPLES

The Canadian Dental Association wishes to affirm its belief that universal adoption of proven





1 preventive measures is essential to the achievement of good  
2 dental health for the nation. Treatment programs insti-  
3 tuted without prior or parallel preventive programs will  
4 not solve Canada's dental health problem.

5 The following statements are based on  
6 adopted policies of the Canadian Dental Association.

7 (a) Prevention

8 The orderly introduction and effective inte-  
9 gration into a dental health program of the  
10 presently known preventive measures would  
11 reduce the prevalence of oral and dental  
12 diseases to a level where they could be  
13 controlled by treatment.

14 (b) Control

15 The most effective and economical way of  
16 controlling the residuum of oral and dental  
17 diseases after all presently known preventive  
18 measures have been exercised by the indivi-  
19 dual and by the community, is early systema-  
20 tic diagnosis and treatment, beginning with  
21 the pre-school child.

22 (c) Auxiliary Personnel

23 The Association believes that action should  
24 be taken to increase the number of dental  
25 auxiliaries and expand the services they  
26 are legally permitted to render.

27 Properly qualified and recognized dental  
28 auxiliaries could be trained to render a  
29 broader scope of service than that presently  
30 recommended.







1 The training of these new auxiliaries must  
2 be at the direction of the dental profession  
3 and should be given at a recognized dental  
4 school.

5 The services that these auxiliaries are  
6 qualified to render must be included in the  
7 prescribed teaching program, and must be  
8 under the direct supervision of qualified  
9 dentists.

10 These services must not include those opera-  
11 tions requiring the scientific knowledge of  
12 the fully-qualified dentists (e.g. case  
13 assessment, treatment planning, cutting or  
14 severing of hard and soft tissues, the  
15 administration of drugs, the making of pres-  
16 criptions) but should include many of the  
17 technical operations and technical parts of  
18 operations for which purpose auxiliary  
19 personnel has been adequately trained.

20 The licensed dentist must retain full respon-  
21 sibility for the patient's welfare.

22 (d) Health Insurance

23 The principle of contributory health insu-  
24 rance is approved, provided that such plan  
25 or plans assure the development of both  
26 preventive and treatment services of the  
27 highest standard and that fairness to both  
28 the recipients of the services and to those  
29 rendering the services be assured.  
30





1 (e) Health Education

2 Intensive health education programs should  
3 precede the introduction of, and accompany  
4 the rendering of dental treatment service  
5 under any plan.

6 (f) Research

7 Accelerated activity in dental research is  
8 essential if the dental health problem is to  
9 be brought under control. Success of any  
10 treatment services plan will depend upon  
11 reduction of dental diseases. Reduction of  
12 dental disease depends upon preventive  
13 measures developed through research. From  
14 the standpoint of both better dental health  
15 and economy, provision for expenditures in  
16 research should be a part of plans for dental  
17 treatment services.

18 I should like to very briefly state two over-  
19 all points related to dental services which we believe to  
20 be important. First, there exists a great need for  
21 trained bodies and facilities. Over a twenty-year period  
22 the profession has in every possible way brought to the  
23 attention of authorities the need for the expansion of  
24 teaching facilities. Until recently facilities for produ-  
25 cing graduate dentists in this country remained stationary  
26 while the population practically doubled. It is our hope  
27 the Commission will examine this situation very carefully.

28 Second, dental disease has an exceedingly  
29 high incidence and is recurring in nature. In these  
30 respects it differs somewhat from other diseases. As a







1 consequence, in our opinion, it is necessary to plan in  
2 a different manner if the dental health of the nation is  
3 to be improved. The nature of dental disease is such  
4 that a program of prevention and control is mandatory if  
5 success is to be achieved. Such a program can only be  
6 instituted among the youngest age groups of the nation.

7 We hope the Commission will think of the  
8 different approach in this respect and take cognisance of  
9 these matters in their deliberations.

10 Again, I express our pleasure in assisting  
11 the Commission in this study in any possible manner.

12 Thank you.

13 THE CHAIRMAN: Thank you very much Mr.  
14 Gullett.

15 Ontario Retail Pharmacists' Association?

16 MR. WARD: Mr. Chairman, and members of the  
17 Commission, my name is Arthur Ward. I am a retail pharma-  
18 cist operating here in Ottawa and an official of the  
19 Ontario Retail Pharmacists' Association. We have submitted  
20 to your Secretary a written brief. I will now read it  
21 with a few word changes but no change in context.

22 In accordance with the terms of reference of  
23 the Royal Commission, the Ontario Retail Pharmacists'  
24 Association would request that the scope of the investiga-  
25 tion include specific areas and problems concerning retail  
26 pharmacy.

27 The O.R.P.A. suggest that the committee  
28 research the place of the drug store in the health team -  
29 i.e., the place of the dispensing Pharmacy in the distri-  
30 bution of prescribed pharmaceuticals, narcotics, controlled





1 drugs, poisons and dangerous drugs in urban as well as  
2 rural districts, to do so the O.R.P.A. believes it would  
3 be useful to retrace the development of the traditional  
4 community pharmacy in the three main directions of its  
5 evolution.

6 FIRST: Development towards the strictly  
7 Prescription Pharmacy.

8 SECOND: Development towards the super  
9 drugstore, the shopping centre and the  
10 discount house.

11 THIRD: The quiet expansion of the tradi-  
12 tional community pharmacy to meet the needs  
13 of the community.

14 To chart the future of Pharmacy in the health  
15 team it would seem that the problem of paramount impor-  
16 tance is whether or not the drug store as it is presently  
17 constituted is capable of meeting its obligations and to  
18 determine the above we suggest that enquiries be made with  
19 respect to the following:

- 20 1. Wage-hour structure of various sized  
21 units of the above three classifications.
- 22 2. Profit and loss picture of the above  
23 three classifications.
- 24 3. The percentage of dispensing which is  
25 done in pharmacies as compared to the dispen-  
26 sing done by physicians, as well as their  
27 nurses, receptionists and others regardless  
28 of the qualifications, legislative and other-  
29 wise, of the latter.
- 30 4. To what extent this dispensing by







1 non-Pharmacists affects the legitimate  
2 activity of the Pharmacy and its effect on  
3 the price of drugs to a patient.  
4 5. The effect of Commercial Insurance  
5 Companies with their medical and major  
6 medical policies on drug utilization.  
7 6. The effect of hospital, medical and  
8 pharmaceutical prepayment.  
9 7. The effect of labour-management contracts  
10 covering health care.  
11 8. The effect of in-patient dispensing on  
12 the hospital cost. The effect of out-patient  
13 dispensing by hospitals on private pharmacy  
14 practice.  
15 9. The effect of D.V.A. and medical depots  
16 on Pharmacy practice.  
17 10. The effect of Provincial welfare and  
18 social service programs on the pharmacists  
19 dispensing practice.  
20 11. The effect of duties and excise taxes,  
21 etc., on the final price to a patient.  
22 12. The effect of pricing methods and in  
23 this connection,  
24 (a) The desirability of a more standard  
25 method of calculating prices and professional  
26 fees.  
27 (b) The desirability of Government price  
28 controls at the patient level.  
29 13. The existence and/or usefulness of a  
30 generic language for identifying single drugs





1 and compounds.

2 14. Dominion wide examination of pharma-  
3 cists.

4 15. Future requirements of pharmacists and  
5 the conditions affecting enrolment in Phar-  
6 macy colleges.

7 The above questions relating to areas under  
8 study pre-suppose that the Royal Commission has access to  
9 the evidence of the Select Committee on Drugs of the  
10 Ontario Legislature as well as the open hearings regarding  
11 the Restrictive Trades Practices Commission.

12 The O.R.P.A. would hope that with this out-  
13 line, the results of previous hearings and the exploration  
14 of areas opened up by the above questions would be of  
15 assistance to the Royal Commission in assessing the past  
16 performance, the present usefulness and the future direc-  
17 tion of Pharmacy in the Health picture.

18 Thank you.

19 THE CHAIRMAN: We are obliged to you Mr.  
20 Ward.

21 THE SECRETARY: Canadian Physiotherapy  
22 Association?

23 MISS MORGAN: Mr. Chairman and Commissioners,  
24 you will be glad to know that what I have to say is quite  
25 brief. The Canadian Physiotherapy Association is repre-  
26 sented today on a national basis by Mme. Gabrielle  
27 d'Ajzenberg of the National Executive in Montreal, by  
28 myself, Miss Morgan, a Director from Toronto and by Mrs.  
29 Curtis Millar, Executive Secretary.

30 Since incorporation by Dominion Charter in







1 1920, this Association has been intimately concerned with  
2 the development of physiotherapy in both the training and  
3 treatment fields.

4           Physiotherapy is one of the "essential  
5 services" mentioned in Federal and Provincial hospitaliza-  
6 tion acts; it is in increasing demand and is used exten-  
7 sively by the medical profession in the treatment of the  
8 sick and injured.

9           Any study or enquiry, therefore, which is  
10 made into health services for the Canadian people, must,  
11 we submit, include detailed consideration of physiotherapy  
12 services and the means of securing and implementing them.

13           With the rapidly changing patterns of  
14 medical care, it has not been possible to meet the  
15 increased demands of health services for physiotherapists,  
16 nor to engage in research and clinical studies so necessary  
17 for the growth and development of the profession.

18           The Association will be submitting a brief  
19 to the Royal Commission in which the following main points  
20 will be discussed, in order to effect improved physio-  
21 therapy services, and is particularly interested in the  
22 following spheres:

- 23           1. The place of physiotherapy in health  
24           and rehabilitation programmes; it's value  
25           and relationship to the medical profession.
- 26           2. Standards of training and ethical prac-  
27           tice.
- 28           3. Present inadequate supply and estimated  
29           demand for therapists.
- 30           4. Facilities for training and the need for





1 expansion.  
2 5. Ways and means of meeting the increasing  
3 demand for therapists.

4 6. The encouragement of research and clinical  
5 studies in the field of physiotherapy.

6 Please be assured of our full co-operation  
7 with the Commission in this most important study.

8 THE CHAIRMAN: Thank you very much Miss  
9 Morgan.

10 Ladies and gentlemen, we are going to adjourn  
11 at this time and we will resume the hearings at 2 o'clock.  
12 Now before we break off, I just want to remind you again  
13 that anyone, any person, any individual who may wish to  
14 be heard here at this hearing will have an opportunity  
15 during the noon adjournment to register with the Secretary.

16 Then too, in connection with these hearing  
17 aids with which you have been provided, for the simulta-  
18 neous translation, we will arrange to provide them as long  
19 as they are needed for the hearing, turning them in, of  
20 course, when you have no further need, as the hearing is  
21 concluded or as you are leaving before the end of the  
22 hearing.

23 We will adjourn until 2 o'clock.

24  
25 --- Luncheon adjournment.

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27  
28  
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30







1 ---On resuming at 2:00 p.m.

2 THE CHAIRMAN: Come to order, please.

3 Mr. Secretary, are you ready to proceed?

4 THE SECRETARY: Yes, sir.

5 The Canadian Medical Association.

6 DR. QUINTIN: Mr. Chairman, members of the  
7 Royal Commission on Health Services, my name is  
8 Quintin and I come from Sherbrooke, Quebec. I am  
9 the Chairman of the General Council of the Canadian  
10 Medical Association.

11 The group which appears before you at this  
12 preliminary public hearing is representative of the  
13 voluntary national organization of the medical  
14 profession of Canada. We desire to present two  
15 submissions at this time. One, entitled "Some  
16 Characteristics of the Medical Profession of Canada",  
17 is intended to acquaint the members of this Royal  
18 Commission with certain basic information on the  
19 qualifications, the organization, the policies and  
20 the beliefs of the profession, because we feel that  
21 it will serve as a useful orientation for the  
22 medical submissions that you will subsequently hear.  
23 The first half of this submission will be discussed  
24 by Dr. Jacques Leger of Montreal who represents  
25 l'Association des Medecins de Langue Francaise du  
26 Canada, and the second portion by Dr. G.E. Wodehouse  
27 of Toronto, Honorary Treasurer of The Canadian Medical  
28 Association and Chairman of our Executive Sub-Committee  
29 on Health Services. They are supported in this  
30 presentation by Dr. J.A. McMillan of Charlottetown,





1 Dr. L.R. Rabson of Winnipeg, who are members of the  
2 Executive Sub-Committee on Health Services, and also  
3 by Dr. A.D. Kelly of Toronto, the General Secretary  
4 of the Canadian Medical Association.

5 Dr. G.W. Halpenny, President of the Canadian  
6 Medical Association, asks me to say that only his  
7 attention to his presidential duties in western  
8 Canada prevents his attendance here today.

9 Our second document, which is entitled  
10 "Comments of the Medical Profession on the Terms  
11 of Reference of the Royal Commission on Health Services",  
12 represents the doctors' viewpoint on the scope of  
13 your inquiry, and it will be presented at this time  
14 by our secretary, Dr. A.D. Kelly.

15 DR. KELLY: Mr. Chairman, members of the  
16 Royal Commission on Health Services, as Dr. Quintin has  
17 stated, my name is Kelly, and I am here to present to  
18 you the composite viewpoint of the two largest medical  
19 organizations in Canada, l'Association des Medecins  
20 de Langue Francaise du Canada which has a membership  
21 of 5,300 doctors, and the Canadian Medical Association,  
22 which has a membership of 15,000 and some doctors.

23 The medical profession is glad to take  
24 advantage of the invitation conveyed in the notice of  
25 this preliminary hearing to the effect that "this  
26 Commission welcomes from the start suggestions from the  
27 public relating to the scope of its enquiry."

28 In this analysis of your Terms of Reference  
29 we undertake to call to your attention those factors  
30 which seem to us appropriate in the comprehensive







1 study of present and future health services in Canada  
2 which you will undertake. Your remit portrays your  
3 task in broad terms in the first paragraph of the Order-  
4 in-Council which establishes this Commission, where  
5 it is stated "it is considered to be in the public  
6 interest to have a comprehensive and independent study  
7 made of the needs of the Canadian people for health  
8 services and the resources available to meet such  
9 needs with a view to recommending methods of ensuring  
10 that the best possible health care is available to all  
11 Canadians."

12 The medical profession would endorse this  
13 objective and would offer its aid in assisting you in  
14 any studies which you will undertake.

15 We note with approval that the concept of  
16 quality is evident in the language of your instructions;  
17 "improving", "best possible", "adequate", "a high rate  
18 of scientific development" are phrases which strike  
19 a responsive note with doctors and our contributions  
20 to your studies will be framed with this in mind.

21 In respect of the specific terms of reference  
22 we have undertaken to provide headings which indicate  
23 to us appropriate subjects for study by the Commission.  
24 The list is as exhaustive as possible but it will  
25 doubtless be amplified as your hearings proceed and  
26 as other interested parties provide you with their  
27 interpretation of the scope of your enquiry.

28 (a) "THE EXISTING FACILITIES AND METHODS FOR PROVIDING  
29 PERSONAL HEALTH SERVICES INCLUDING PREVENTION,  
30 DIAGNOSIS, TREATMENT AND REHABILITATION".

(We distinguish between the use of the word





"facilities" in term (a) and term (f). In the former instance we interpret the word to refer to means of facilitating health services and in the latter, to physical facilities).

1. Private Medical Practice as a Facility and Method of Providing Personal Health Services

- 1) Private practice represents the major method by which personal health services are provided in Canada today. The evolution of private practice has proceeded far from the concept of the doctor whose resources were contained in his head and his little black bag. The effect of specialization, better diagnostic and therapeutic equipment, the employment of paramedical personnel, progress in hospital and other institutional developments and professional and public education have all enhanced the services which the private practitioner is able to furnish. Scientific advances, communications and transportation have all improved the quality and availability of private medical practice.
- 2) Patterns of Practice -
  - a) family physician or general practitioner
  - b) specialist
    - 1) distribution
    - 2) efficient use of special equipment
    - 3) consultations and referrals

Both the family physician and the specialist may provide his services as an individual or







1 as a member of a group; and it will no doubt  
2 come to your attention that there are merits  
3 in those approaches to private practice.

4 3) Essentials of Private Practice -

5 a) Personal responsibility of physician  
6 to his patient

7 b) Freedom of patient to choose and  
8 change his medical attendant

9 c) Freedom of doctor to choose type and  
10 location of practice.

11 4) The evolution and growth of specialism

12 5) The identification, training and utilization  
13 of paramedical personnel.

14 6) The function of the private practitioner  
15 in prevention, diagnosis, treatment and  
16 rehabilitation fields.

17 7) The role of the private practitioner and  
18 the philosophy of the medical profession in  
19 the development of voluntary insurance for  
20 medical services:

21 a) sponsorship by the profession

22 b) role of prepaid medical care plans  
23 as insurance mechanisms

24 c) support by the profession who exercise  
25 controls

26 d) the status of the subscriber remains  
27 as a private patient

28 e) the voluntary coverage of persons by:

29 1) TCMP plans

30 2) Commercial carriers





1 3) Co-ops

2 4) Company or union-operated plans

3 5) Municipal plans in certain areas  
4 of the country.

5 8) The role of the private practitioner in  
6 Industrial Health Programs.

7 9) The relationship of private practice to  
8 health services and facilities provided by  
9 voluntary agencies in prevention, diagnosis,  
10 treatment, rehabilitation and research -

11 a) the area of co-operation

12 b) the assistance provided by paramedical  
13 personnel

14 c) the flexibility of voluntary agencies

15 d) the role of the voluntary agencies  
16 in the training of specialists.

17 10) The operation of voluntary insurance in  
18 the provision of extended health benefits  
19 for paramedical services, disability insurance  
20 and out of work benefits.

21 II. Governmental Agencies

22 Many services provided by governmental agencies  
23 were established at the prodding and request of the  
24 medical profession to meet specific needs. In almost  
25 all areas private practitioners play a substantial  
26 part in the implementation of these programs, i.e.  
27 they are provided in part by full-time physicians and  
28 in equal or greater amount by physicians in private  
29 practice.  
30







1) Health Services administered and financed  
by the Federal Government.

- a) Indian and Northern Health Services
- b) D.V.A.
- c) Immigration and Sick Mariners Service
- d) Armed Forces
- e) Other federal responsibilities - e.g. RCMP
- f) Consultative services which are rendered  
to the provinces.
- g) Medical Services in federal penitentiaries
- h) other

2) Health Services Financed but not administered  
by the Federal Government

(1) National Health Grants -

- a) The National Health Grants program -  
amounts available and areas covered.

- b) Utilization by provinces

(2) Medical Services Insurance -

- a) Medical insurance coverage for employees  
of federal departments.
- b) Medical insurance coverage for dependents  
of Armed Services personnel, dependents  
of R.C.M.P., etc.

3) Health Services administered and financed  
by provincial and/or municipal governments.

(1) Public Health Services -

- (a) preventative medicine
- (b) environmental hygiene and sanitation
- (c) other

(2) Mental Health Services. We will have  
something to say about the mental health





1 services. I feel certain that this  
2 Commission's study of this important area  
3 of health services will be thorough and  
4 I hope very helpful.

5 (3) Tuberculosis control

6 (4) Cancer programs

7 (5) Alcohol and drug addiction

8 (6) Provincial Laboratories

9 (7) The provision of biologicals by the  
10 provincial Department of Health which have  
11 meant so much in the control of many  
12 communicable diseases.

13 (8) Venereal disease - treatment and control

14 (9) Other

15 4) Health Services financed but not  
16 administered by Provincial Governments

17 (1) Social assistance medical services programs

18 (2) Medical services for chronically ill,  
19 including rehabilitation. I have no doubt  
20 you will hear much about the recent  
21 improvements in this essential area of  
22 health care

23 (3) We would mention the blood transfusion  
24 services provided by the Canadian Red  
25 Cross and which have recently been  
26 considerably aided by a substantial  
27 contribution from the provincial  
28 government.

29 (4) Other.  
30







5) Health Services Programs administered by  
Provincial Boards but not financed by the  
Provinces

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(1) Workmen's Compensation Board and  
other commissions which are financed  
not by taxation but by contributions  
of another sort.

(2) Other

6) The Hospital as an element of modern  
Medical Care

---

- (1) Active Treatment hospitals
- (2) Convalescent hospitals
- (3) Chronic hospitals
- (4) Diagnostic services
- (5) Out-patient and emergency services
- (6) Alternate care programs - e.g. home  
care programs and homes for the aged
- (7) Special treatment facilities - e.g.
  - a) Cardio-vascular units
  - b) Therapeutic radiology
  - c) Radio-isotopes
  - d) Rehabilitation
  - e) Artificial kidney or other special  
units
  - f) Other

7) The Hospital Insurance and Diagnostic  
Services Act

---

- a) History and current operation
- b) Its effect on -
  - (1) Hospital costs
  - (2) Availability of beds
  - (3) Medical practice





(4) Quality of medical care

(5) Undergraduate and postgraduate  
medical education

(6) Clinical research.

III. Drugs and appliances, provided by

1. Private purchase. We suggest you may look  
at it from the point of view of the amounts  
spent on -

(a) Doctor prescribed

(b) Self-medication

2. Government provided

3. Provided through voluntary organizations.





IV. Preventive, Diagnostic, Therapeutic and Rehabilitative Services

Correlation of existing services under the facilities mentioned in this term of reference.

(b) "METHODS OF IMPROVING SOME HEALTH SERVICES"

Under this heading the Commission and interested organizations will doubtless analyze the adequacy of the services set out under the first term of reference, comment on these deficiencies noted and recommend actions which should be taken to correct these deficiencies, including the extension of medical services insurance to those not now insurable. Discussion of physical facilities should be deferred as it relates to term (f).

(c) "THE CORRELATION OF ANY NEW OR IMPROVED PROGRAM WITH EXISTING SERVICES WITH A VIEW TO PRODUCING IMPROVED HEALTH SERVICES"

This term relates in part to the services and agencies mentioned in (a) and (b) insofar as they may require integration, correlation and the elimination of duplication.

However, it seems to us to afford the opportunity to project possible developments of the future. Many of these developments may well be dependent on new scientific discoveries and their application and the trend is impossible to predict with any great accuracy. Health services now in the early stages of their development should be studied because they may point to the future. Included in this category would be geriatric services, that is services to the aged, home nursing and homemaker







1 programs, control of alcoholism, prevention and control  
2 of accidents and poisoning, the medical aspects of traffic  
3 accidents and programs to promote healthful recreation and  
4 physical fitness.

5 (d) "THE PRESENT AND FUTURE REQUIREMENTS OF PERSONNEL TO  
6 PROVIDE HEALTH SERVICES"

7 This seems to us in the medical profession  
8 a crucial point, and we will undertake to file a study of  
9 manpower which we have recently completed, projected to  
10 the year 1980, and I may say that it is no secret that it  
11 portrays the need for a considerable amplification of the  
12 facilities of Canada's existing medical schools and for  
13 the establishment of new Faculties of Medicine.

14 An endeavour should and will be made to  
15 define the need of specialists by category and to portray  
16 the postgraduate educational facilities required to train  
17 them.

18 Similar studies on the paramedical personnel  
19 would be desirable.

20 Your term instructs you to consider:

21 (e) "METHODS OF PROVIDING ADEQUATE PERSONNEL WITH THE  
22 BEST POSSIBLE TRAINING AND QUALIFICATIONS FOR SUCH  
23 SERVICES"

24 Leading out of the studies mentioned under  
25 (d) the Commission will doubtless consider the problem of  
26 attracting to the health professions adequate numbers of  
27 academically qualified and well-motivated recruits. The  
28 economic, social and other reasons for the current decline  
29 in well-prepared applicants for training should be explored.

30 The role of The Canadian Medical Association





1 in approving hospitals for the training of junior interns  
2 and that of the Royal College of Physicians and Surgeons  
3 of Canada in identifying hospitals for advanced graduate  
4 training in the specialties are pertinent and you will  
5 hear both of them. The approved training programs for  
6 laboratory technologists, radiological technicians,  
7 physical and occupational therapists, university and  
8 hospital training schools for nurses, training facilities  
9 for nurses' aides and other health workers should, and I  
10 have no doubt will, be assessed by you.

11 The Association of Canadian Medical Colleges  
12 will present a definitive submission on undergraduate  
13 medical education and the pressing problems associated  
14 with this fundamentally important element of training.

15 The particular responsibilities of the  
16 teaching hospitals should be studied.

17 Continuing education of the practising physi-  
18 cian by refresher courses, institutes, symposia and  
19 conventions should be examined as well as the profession's  
20 efforts to bring to the doctor in his own locality post-  
21 graduate education in the form of clinics and scientific  
22 meetings.

23 The financial problem of the unestablished  
24 practitioner may be looked at as well as the desirability  
25 of achieving optimum distribution. The effect of income  
26 tax regulations on expenses of practice and of refresher  
27 courses have some slight pertinence in this connection.

28 Your term tells you to study:

29 (f) "THE PRESENT PHYSICAL FACILITIES AND THE FUTURE  
30 REQUIREMENTS FOR THE PROVISION OF ADEQUATE HEALTH







1 SERVICES"

2 Existing deficiencies in facilities should  
3 be studied here, together with the cost of correcting  
4 them. These deficiencies will consist of hospital beds  
5 of all types, rehabilitative facilities, teaching and  
6 research diagnostic facilities as well as the observed  
7 deficiencies in public health and sanitary arrangements.

8 (g) "THE ESTIMATED COST OF HEALTH SERVICES NOW BEING  
9 RENDERED TO CANADIANS WITH PROJECTED COSTS OF ANY  
10 CHANGES THAT MAY BE RECOMMENDED FOR THE EXTENSION  
11 OF EXISTING PROGRAMS OR FOR ANY NEW PROGRAMS SUG-  
12 GESTED"

13 Previous attempts to estimate the cost of  
14 health services have been prepared on a national basis to  
15 include governmental and private expenditures. It is  
16 assumed that the Commission will provide itself with this  
17 basic information and that it will be made available to  
18 interested parties for their calculations on future require-  
19 ments.

20 The projected costs of correcting deficien-  
21 cies will arise out of each submission's appraisal of  
22 existing and projected requirements. The cost estimates  
23 will necessarily be inexact but we think that they are  
24 unlikely to err on the side of over-estimation.

25 Your term instructs you to look at:

26 (h) "THE METHODS OF FINANCING HEALTH CARE SERVICES AS  
27 PRESENTLY SPONSORED BY MANAGEMENT, LABOUR, PROFES-  
28 SIONAL ASSOCIATIONS, INSURANCE COMPANIES, OR ANY  
29 OTHER MANNER"

30 Information as to the specific insurance





1 arrangements listed should be available from a wide variety  
2 of sources. The difference between service and indemnity  
3 programs and the attitude towards co-insurance and deduc-  
4 tible features should preferably be explored.

5 The medical profession's submission will  
6 elaborate on the Statement on Medical Services Insurance  
7 and an outline of the development of prepaid medical care  
8 under the sponsorship of the profession will be provided.  
9 Trans-Canada Medical Plans' national submission will be  
10 particularly appropriate here.

11 (i) "THE METHODS OF FINANCING ANY NEW OR EXTENDED PROGRAMS  
12 WHICH MAY BE RECOMMENDED"

13 The possibility of personal financing of new  
14 or extended programs by the self-supporting elements of  
15 society should be explored in the first instance.

16 In the case of persons in need of assistance  
17 by reason of inadequate income, age or state of health,  
18 it appears likely that public funds will be required.  
19 The coverage of the currently uninsurable groups by sub-  
20 sidy of premium or otherwise would in our view be desi-  
21 rable. The realities of a means or needs test should be  
22 examined. The taxing powers of Federal and provincial  
23 governments bear a direct relationship to their ability  
24 to finance new or extended programs and the Commission  
25 will doubtless examine very carefully the economics of the  
26 situation in relation to traditional Dominion-provincial  
27 spheres of authority in matters of health.

28 (j) "THE RELATIONSHIP OF EXISTING AND ANY RECOMMENDED  
29 HEALTH CARE PROGRAMS WITH MEDICAL RESEARCH AND THE  
30 MEANS OF ENCOURAGING A HIGH RATE OF SCIENTIFIC







1        DEVELOPMENT IN THE FIELD OF MEDICINE IN CANADA"

2                    The Association of Canadian Medical Colleges  
3 and the Medical Research Council will likely take the lead  
4 in discussing research. C.M.A. policy states that insu-  
5 rance mechanisms should not act to inhibit research, and  
6 we infer that research, whether fundamental or clinical,  
7 should not be basically dependent on finances derived  
8 from medical or hospital services insurance.

9 (k)    "THE FEASIBILITY AND DESIRABILITY OF PRIORITIES IN  
10        THE DEVELOPMENT OF HEALTH CARE SERVICES"

11                   This, of course, will vary with each presen-  
12 tation as different needs will require different priori-  
13 ties. We should, however, keep in the foreground the need  
14 for subsidized medical insurance for specified groups, the  
15 requirements of medical education and the need to further  
16 develop many services, notably mental health services,  
17 which have been traditionally the responsibility of govern-  
18 ments. The estimate of costs previously ascertained will  
19 doubtless influence the Commission in assigning priorities.

20 (1)    "SUCH OTHER MATTERS AS THE COMMISSIONERS DEEM APPRO-  
21        PRIATE FOR THE IMPROVEMENT OF HEALTH SERVICES TO ALL  
22        CANADIANS"

23                   This is a catch-all category for the presen-  
24 tation of any matter which does not seem to fit in any  
25 preceding category.

26                   We have no comment at this time on matters  
27 not covered by your specific Terms of Reference. Thank  
28 you sir.

29                   THE CHAIRMAN: Dr. Kelly, before you leave  
30 the podium. In your presentation you listed many areas







1 which you suggest the Commission ought to look into, and  
2 for that we are indebted to you and grateful to you for  
3 the study that has been made of it. Particularly under  
4 the item (a) that you referred to, you listed many areas  
5 that the Commission ought to look into. May I put this  
6 question to you? Can the Commission expect some comment  
7 from the Canadian Medical Association in its own submis-  
8 sion to be made later to cover the points it has recommen-  
9 ded that the Commission look into?

10 DR. KELLY: Mr. Chairman, I can give you a  
11 categorical assurance that the Canadian Medical Associa-  
12 tion and L'Association Médecins de Langue Française du  
13 Canada will make comments on each of these points we have  
14 drawn to your attention. I think that many of our provin-  
15 cial divisions and our affiliated specialist societies  
16 will also comment on those areas particularly pertinent  
17 to them. I think it will be no lack of comment of those  
18 doctors on the view of your areas of study. You will  
19 have it certainly from ten provinces and nationally from a  
20 number of organizations.

21 THE CHAIRMAN: Thank you very much. We are  
22 indebted to you for that answer.

23  
24  
25 -

26  
27  
28 -





CERTAINS ASPECTS DE LA PROFESSION MÉDICALE AU CANADA

EXPOSÉ PRÉLIMINAIRE

a la

COMMISSION ROYALE D'ENQUÊTE SUR LES SERVICES DE SANTÉ

préparé et soumis par

L'ASSOCIATION DES MÉDECINS DE LANGUE FRANÇAISE DU CANADA  
326 est, boul. St-Joseph, Montréal 14, P.Q.

et

L'ASSOCIATION MÉDICALE CANADIENNE  
C.M.A. House, 150, rue St.George, Toronto 5, Ont.

27 septembre 1961

Presenté par:

Dr. G.W. Halpenny, Président de l'Association Médicale  
Canadienne, 1414, rue Drummond, Montréal 25.

Dr. T.J. Quintin, Président du Conseil Général de  
l'Association Médicale Canadienne, 422, rue  
London, Sherbrooke, P.Q.

Dr. Jacques Léger, représentant de l'Association des  
Médecins de Langue Française du Canada  
(Président de la filiale de Québec)

Dr. G.E. Woodhouse, Trésorier Honoraire de l'Association  
Médicale Canadienne et Président du Sous-comité  
exécutif sur les Services de Santé, 284 ouest,  
avenue St.Clair, Toronto 7.

Dr. J.A. McMillan, membre du Sous-comité exécutif sur  
les Services de Santé, Charlottetown Clinic,  
1, rue Rockford, Charlottetown.

Dr. L.R. Rabson, membre du Sous-comité exécutif sur les  
Services de Santé, Mall Medical Group, 280,  
boul. Memorial, Winnipeg 1.

Dr. A.D. Kelly, Secrétaire-Général de l'Association  
Médicale Canadienne, 150, rue St.George,  
Toronto 5.







1 DR. JACQUES LEGER: Monsieur le Président,  
2 madame et messieurs les membres de la Commission Royale  
3 d'enquête sur les Services de Santé, l'exposé suivant  
4 traite de certains aspects de la profession médicale du  
5 Canada.

6 1. Cet exposé préliminaire des médecins  
7 du Canada est soumis conjointement par l'Association  
8 Médicale Canadienne qui compte (15,131 membres) et  
9 l'Association des Médecins de Langue Française du Canada  
10 qui en compte (5,300 membres) en vue de familiariser la  
11 Commission Royale sur les Services de Santé avec certains  
12 faits saillants de la profession médicale.

13 2. Comme notre demande au premier ministre  
14 semble avoir joué un certain rôle dans la décision d'entre-  
15 prendre cette étude sur les services de santé au Canada,  
16 nous sommes heureux de constater que votre mandat permet  
17 la plus entière liberté dans l'enquête que vous devez  
18 mener. La latitude même des recommandations qui ont été  
19 faites nous porte à croire qu'aucun point particulier ne  
20 sera considéré plus qu'un autre, mais que tous les services  
21 de santé seront étudiés conjointement. Il est à noter de  
22 plus que le concept de qualité se retrouve tout au cours  
23 de votre projet d'étude. Ce concept est d'ailleurs en  
24 parfait accord avec les principes de base de la profession  
25 médicale et devra nous aider dans nos considérations  
26 ultérieures. Il est donc souhaitable que le temps nous  
27 permette une étude aussi complète que possible.

28 3. Conformément aux responsabilités  
29 constitutionnelles et traditionnelles des provinces en  
30 matière de santé, l'organisation de base de la profession





1 médicale est provinciale. L'Association Médicale Cana-  
2 dienne est une fédération de dix divisions provinciales,  
3 alors que l'organisation générale de l'Association des  
4 Médecins de Langue Française du Canada comprend cinq  
5 filiales. Dans l'étude de la Commission Royale ceci revêt  
6 plus qu'un intérêt théorique, car l'aspect régional du  
7 problème est de première importance.

8 4. Nous nous rallions à la définition de la  
9 santé telle qu'établie dans le préambule de la charte de  
10 l'Organisation Mondiale de la Santé et je cite: "La santé  
11 est un état de bien-être physique, mental et social et non  
12 seulement une absence de maladie ou d'infirmité".

13 5. L'amélioration de la santé est le  
14 premier but et le devoir quotidien des membres de la  
15 profession médicale. Il serait par ailleurs illusoire de  
16 prétendre que seuls les médecins et la pratique de la  
17 médecine peuvent satisfaire à toutes les exigences de la  
18 santé. Le paragraphe suivant, extrait des recommandations  
19 de l'A.M.C. faites en 1949, est assez explicite à cet  
20 effet. Je cite:

21 "Parmi les facteurs essentiels à la santé  
22 publique se trouvent l'alimentation adéquate,  
23 le logement salubre ainsi que les conditions  
24 générales qui s'y rattachent, les facilités  
25 d'enseignement, l'exercice et le repos;  
26 enfin, et ce qui est important, la conduite  
27 sage et intelligente de l'individu et l'accep-  
28 tation de ses responsabilités personnelles".

29 6. La médecine est un art ancien et une  
30 science qui progresse constamment. Des lois provinciales







1 et un code d'éthique régissent la médecine au Canada;  
2 ceux-ci sont établis dans l'intérêt public afin de garan-  
3 tir que seuls les médecins hautement qualifiés soient  
4 admis aux Régistres de la pratique médicale.

5 7. Les diplômés en médecine sont conférés  
6 par les Facultés de Médecine de douze universités cana-  
7 diennes et les diplômés de ces écoles, au nombre approximatif  
8 de 850 par an, sont la principale source de recrutement  
9 dans toutes les disciplines. Comme préparation à la  
10 carrière médicale, les candidats doivent posséder un degré  
11 universitaire, suivre de deux à quatre ans de cours pré-  
12 médicaux à l'Université et passer avec succès les épreuves  
13 de quatre années d'études médicales pour obtenir leur  
14 diplôme. Avant d'être admis à la pratique de la médecine,  
15 les candidats doivent en plus faire un an d'internat dans  
16 un hôpital reconnu et, dans la plupart des provinces,  
17 passer les examens du Conseil Médical Canadien.

18 8. Plusieurs carrières s'offrent aux  
19 personnes qualifiées en médecine: pratique générale, spécia-  
20 lite, recherche, Santé publique, médecine occupationnelle,  
21 médecine militaire ou administration médicale. Dans  
22 presque tous les cas, une formation post-universitaire est  
23 essentielle, et qu'il suffise de mentionner à titre  
24 d'exemple que les candidats au grade de Fellow du Collège  
25 Royal des Médecins et Chirurgiens du Canada, dans chacune  
26 des vingt-deux spécialités actuellement reconnues, doivent  
27 avoir suivi un entraînement approuvé de cinq ans après les  
28 études régulières de médecine puis subir un examen d'accré-  
29 ditation. Comme sérieuse conséquence de cette longue  
30 période d'entraînement post-universitaire, le médecin







1 atteint l'âge de 30-32 ans avant de commencer un travail  
2 productif lui permettant de se suffire à lui-même.

3 9. D'autres organisations compétentes, dont  
4 l'Association des Écoles de Médecine Canadiennes, présen-  
5 teront plus en détail les problèmes relatifs à l'enseigne-  
6 ment médical au pays. Nous voulons signaler toutefois,  
7 que la profession réalise toute l'importance de la surveil-  
8 lance et de l'amélioration constante de la préparation à  
9 la médecine. Nous sommes fiers, avec raison, de l'excel-  
10 lence de nos Écoles de Médecine au Canada, et nous  
11 reconnaissons que l'avenir de la santé dans notre pays  
12 dépend pour une large part de leur contribution. Nous  
13 espérons que cette Commission Royale se souviendra, dans  
14 toutes ses délibérations et recommandations, que rien ne  
15 doit entraver l'éducation et le recrutement médical; toute  
16 nouvelle suggestion doit être faite dans le but d'améliorer  
17 l'entraînement médical et de favoriser la recherche indis-  
18 pensable au progrès.

19 10. L'étude du rapport médecin-population  
20 nous permet de mesurer approximativement l'étendue des  
21 services médicaux. De 1900 à 1950, la proportion au  
22 Canada a été avec une remarquable constance de l'ordre de  
23 1 pour 980. Nous estimons que le rapport actuel est de 1  
24 pour 880, soit le chiffre le plus favorable jamais atteint,  
25 se comparant avantageusement à ceux des pays les plus  
26 développés du monde occidental. Il faut cependant  
27 constater que les chiffres ci-haut mentionnés représentent  
28 l'ensemble des diplômés en médecine, mais que tous les  
29 médecins ne sont pas nécessairement assignés au soin  
30 immédiat des malades. Nous devons réaliser de plus, que





1 l'immigration des dix dernières années a contribué à  
2 l'effectif médical au Canada; sans cet avantage, ne fut-il  
3 que temporaire, la proportion médecin-population aurait  
4 décliné. En d'autres termes, nous ne produisons pas  
5 suffisamment de médecins au Canada pour faire face à  
6 l'expansion rapide de la population. Les effectifs sont  
7 à peine suffisants pour les conditions actuelles de la  
8 pratique de la médecine, mais ils seront presque certaine-  
9 ment insuffisants pour créer de nouveaux services de santé  
10 ou desservir de nouvelles régions. Nous réalisons que  
11 dans l'esprit de la nouvelle génération de ce pays,  
12 d'autres professions sont plus attrayantes que la médecine  
13 qui exige plus de temps, d'efforts et d'argent pour s'y  
14 qualifier. Il faut admettre que le recrutement médical  
15 pourrait en être sérieusement compromis.

16 11. Bien que le relevé actuel de l'effectif  
17 médical soit satisfaisant, on constate une distribution  
18 inégale entre les provinces. Les médecins s'établissent  
19 de préférence dans les centres urbains, comme c'est  
20 d'ailleurs le fait pour la population en général. Il en  
21 résulte une pénurie de médecins dans les régions éloignées  
22 et dans les centres ruraux; cette pénurie est par ailleurs  
23 compensée dans une certaine mesure par la grande activité  
24 du praticien, surtout s'il est à proximité d'un hôpital,  
25 et la facilité moderne qu'ont les patients de se déplacer.

26 12. Relativement aux services de santé,  
27 les soins aux patients peuvent, en général, être subdivi-  
28 visés en deux catégories principales: premièrement, les  
29 services rendus individuellement et directement, tel est  
30 le cas en pratique privée; puis les services rendus







1 indirectement ou collectivement. Ces deux modes se  
2 complètent et sont essentiels à un système bien équilibré.

3 13. La majorité des médecins canadiens font  
4 de la pratique privée individuellement ou en groupe. Dans  
5 le concept de la pratique privée, il est implicitement  
6 convenu que le médecin a la liberté de s'établir là où il  
7 veut et de pratiquer la spécialité qu'il désire. Le  
8 patient a également le choix de son médecin. Nous sommes  
9 d'avis que ceci aide à maintenir le haut standard de  
10 qualité des services médicaux, et que les différents  
11 facteurs qui entrent en ligne de compte pour la distribu-  
12 tion des médecins, ayant les qualifications requises, sont  
13 dans l'intérêt public. Les méthodes de financement des  
14 services de santé ne doivent pas être préjudiciables à la  
15 qualité de la pratique privée et l'expérience le prouve.  
16 Pour ces médecins, les honoraires payés à l'acte médical  
17 sont, tant pour les patients que pour eux-mêmes, le mode  
18 de rémunération le plus généralement acceptable.

19 14. Les services de santé rendus indirecte-  
20 ment ou collectivement constituent l'autre large champ  
21 d'action vers lequel se sont dirigés plusieurs médecins  
22 canadiens. Dans cette catégorie se situent les hygiénistes  
23 et ceux qui font de la médecine préventive dans tous les  
24 services gouvernementaux, les médecins d'industrie, les  
25 officiers médicaux de compagnies d'assurance, les patholo-  
26 gistes, les bactériologistes, les bio-chimistes, les radio-  
27 logistes en certains cas, les physiâtres, les médecins en  
28 recherche, les professeurs de médecine particulièrement  
29 pour les sciences de base, les médecins d'hôpitaux  
30 d'aliénés, de sanatoria et de centres de rééducation dans





1 les hôpitaux, les administrateurs médicaux d'hôpitaux et  
2 tous les autres médecins dont les fonctions peuvent  
3 difficilement être classifiées. Bien que plusieurs de  
4 ces médecins s'occupent directement du soin des malades,  
5 ils se distinguent de leurs confrères en pratique privée  
6 du fait que leur genre d'occupation ne permet pas aussi  
7 librement le choix du patient et du médecin. Plusieurs  
8 médecins de cette catégorie sont à traitements fixes; par  
9 contre la rémunération à l'acte médical semble préférée  
10 par d'autres; en certains cas la combinaison des deux  
11 méthodes est la solution idéale.

12 15. La confiance mutuelle entre médecin  
13 et patient est un facteur important pour le succès du  
14 traitement et la qualité des soins médicaux. Le terme  
15 rapport médecin-patient décrit un ensemble d'éléments  
16 connexes dont: le libre choix, l'intérêt, la responsabi-  
17 lité, la sympathie et la confiance mutuelle. De bonnes  
18 relations entre médecin et patient assurent à ce dernier  
19 un bénéfice optimum des soins médicaux; dans l'éventualité  
20 contraire, l'art médical est d'application difficile, les  
21 aspects techniques et mécaniques du traitement ne compen-  
22 sant pas. Quelles que soient les méthodes d'assurer des  
23 services cliniques, l'importance de bonnes relations  
24 médecin-patient doit être reconnue.

25 16. Le travail du médecin dans l'applica-  
26 tion des concepts modernes de la santé est complété par  
27 un personnel para-médical considérable. Dire que la méde-  
28 cine moderne exige un travail d'équipe est une figure de  
29 style bien connue, mais elle a ici un sens bien précis si  
30 l'on considère la compétence requise par le personnel







1 suivant étroitement lié au travail médical: dentistes,  
2 vétérinaires, infirmières, ingénieurs sanitaires, admini-  
3 strateurs d'hôpitaux, pharmaciens, techniciens en labora-  
4 toire et en radiologie, aides-garde-malades, dietetistes,  
5 inspecteurs sanitaires, travailleurs sociaux, bibliothé-  
6 caires, archivistes, instructeurs, psychologues, physio-  
7 thérapeutes, thérapeutes de réhabilitation, audiophonistes,  
8 orthophonistes, optométristes, chiropodistes et théra-  
9 peutes respiratoires.

10 17. Pour le bien général, la profession  
11 médicale est regie par un corps légalement constitué appelé  
12 "Collège des Médecins et Chirurgiens de la province  
13 concernée". La Loi Médicale ou la Loi de la Profession  
14 Médicale reconnaît dans chaque province canadienne des  
15 organismes ayant la responsabilité de définir les qualifi-  
16 cations requises pour l'admission à la pratique de la  
17 médecine et l'inscription au Régistre; celui-ci est la  
18 liste officielle des médecins qui ont obtenu leur licence,  
19 permettant ainsi au public d'identifier les médecins.  
20 Dans plusieurs provinces, ce procédé d'inscription, après  
21 études médicales, équivaut officieusement à l'octroi d'une  
22 licence de pratique. Dans d'autres provinces, les gradués  
23 des écoles de médecine canadiennes doivent passer les  
24 examens du Conseil médical du Canada en plus de ceux de  
25 l'Université et faire un an d'internat avant d'être  
26 éligible à l'inscription. Les gradués des écoles de  
27 médecine non-canadiennes doivent également subir les  
28 examens du Conseil Médical du Canada et satisfaire, selon  
29 le cas, à d'autres exigences provinciales. Une exception  
30 est cependant faite pour les médecins inscrits sur la







1 liste du Conseil Général Médical de Grande-Bretagne (Home  
2 List) leur permettant, en vertu d'une entente réciproque,  
3 d'être inscrit au registre sans examen dans les provinces  
4 d'Alberta, Saskatchewan, Manitoba, Nouvelle-Ecosse, Ile-  
5 du-Prince-Edouard et Terre-Neuve. Il a déjà été discuté  
6 antérieurement du rôle que joue l'immigration pour combler  
7 la déficience actuelle de l'effectif médical au Canada.  
8 La majorité des médecins immigrants inscrits sont de  
9 Grande-Bretagne, les autres par contre viennent de dif-  
10 férents pays. Une étude préliminaire des besoins du  
11 Canada en médecins, sera incessamment versée au dossier,  
12 ainsi que l'a mentionné le docteur Kelly, et l'invitation  
13 récente de la Commission Royale, de procéder à un inven-  
14 taire médical complet a été acceptée avec empressement.

15 18. Dans l'intérêt public, les bureaux  
16 provinciaux de médecine possèdent des pouvoirs discipli-  
17 naires très étendus vis-à-vis leurs membres, permettant  
18 même de rayer des cadres ceux qui se rendent coupables  
19 d'actes dérogatoires à l'honneur de la profession médicale.

20 19. La profession exerce une auto-discipline  
21 dans bien d'autres cas. L'Association Médicale Canadienne  
22 a publié un Code d'Éthique, basé sur les traditions recon-  
23 nues de la médecine; celui-ci est constamment révisé et  
24 maintenu à date, et sert de guide pour la directive et  
25 l'éthique professionnelles.

26 20. Etant donné qu'une partie du travail  
27 médical s'effectue en milieu hospitalier, les médecins  
28 se sont imposés des standards élevés pour le soin des  
29 patients traités dans leurs institutions. Les comités  
30 sur lesquels ils siègent bénévolement sont des exemples,





1 tel le Comité des Créances qui a pour fonction d'étudier  
2 le curriculum des candidats qui désirent faire partie du  
3 personnel médical de l'hôpital et accorder ou limiter les  
4 privilèges selon la compétence. Une fois acceptés parmi  
5 le personnel médical, le travail de chacun des membres  
6 continue d'être contrôlé par ce comité. Le Comité des  
7 Tissus étudie les rapports anatomo-pathologiques des  
8 pièces prélevées au cours d'interventions chirurgicales  
9 pour contrôler le bien-fondé des indications opératoires.  
10 Le Comité des Admissions et des Congés s'assure de l'usage  
11 judicieux des lits d'hôpitaux et le Comité des Dossiers  
12 voit à ce que toutes informations pertinentes soient  
13 promptement inscrites aux dossiers des malades. Le  
14 "Medical Audit" et les Études sur l'Activité profession-  
15 nelle sont de nouveaux moyens pour apprécier la qualité  
16 des services médicaux dans les hôpitaux.

17 21. Le Conseil Canadien d'Accréditation  
18 des Hôpitaux est une organisation nationale fondée en vue  
19 de maintenir et de promouvoir les plus hauts standards de  
20 soins aux malades. Les représentants de l'Association  
21 Canadienne des Hôpitaux, du Collège Royal des Médecins et  
22 Chirurgiens, de l'Association des Médecins de Langue  
23 Française du Canada et de l'Association Médicale Canadienne  
24 constituent les membres de cet organisme. Le travail du  
25 Conseil est financé par des contributions versées par ces  
26 associations, et récemment par celles de neuf gouvernements  
27 provinciaux.

28 22. Les différents groupements volontaires  
29 de la médecine organisée sont représentés, sur le plan  
30 national, par deux organisations principales: l'Association







1 des Médecins de Langue Française du Canada et l'Associa-  
2 tion Médicale Canadienne. Plusieurs médecins sont à la  
3 fois membres de ces deux associations. Le droit de pra-  
4 tique ne dépend pas de l'adhésion à ces associations dont  
5 la survie et l'influence dépendent de la collaboration  
6 des membres.

7 23. L'Association des Médecins de Langue  
8 Française du Canada est de portée nationale et comprend  
9 cinq divisions ou filiales: Provinces de l'ouest, Ontario,  
10 Québec, Nouveau-Brunswick et Nouvelle-Écosse.

11 24. Les principes de base de l'Association  
12 sont stipulés spécifiquement dans la Charte, à savoir:

13 "Elle a été formée dans les buts suivants:  
14 rallier sur un terrain commun, culturel et  
15 professionnel, les médecins de langue fran-  
16 çaise du Canada; organiser des congrès  
17 scientifiques; publier des revues et péri-  
18 diques médicaux et scientifiques; sauvegar-  
19 der les intérêts professionnels de ses  
20 membres et enfin encourager ou établir  
21 d'autres oeuvres analogues".

22 Et pour terminer ma contribution à cet exposé  
23 et avant de laisser la parole à mon collègue, le  
24 docteur Wodehouse, j'aimerais me faire l'interprète  
25 de l'Association des médecins de langue française  
26 du Canada pour exprimer le plaisir que nous avons eu  
27 à coopérer dans la préparation de ce travail conjoint.

28 Je profite de l'occasion pour laisser  
29 entrevoir aux membres de la Commission l'orientation  
30





1 et certains aspects que comportera notre mémoire  
2 éventuellement.

3 Je veux vous dire que nous nous proposons  
4 de scruter l'aspect constitutionnel des services de  
5 santé au Canada.

6 Quant aux autres aspects envisagés, notre  
7 Association n'en n'est pas à ses premières armes dans  
8 l'étude des problèmes de santé. Qu'il me suffise de  
9 mentionner, pour le moment, que dès 1951, lors d'un  
10 congrès annuel de notre Association, six conditions  
11 essentielles concernant l'assurance-santé ont été  
12 exprimées et adoptées sous forme de vœux qui, par la  
13 suite, ont été transmis aux principaux organismes  
14 médicaux du Canada et aux ministères de Santé de  
15 provinces Canadiennes, et en voici le texte:

16 À savoir que les autorités provinciales et  
17 les Collèges de Médecins et Chirurgiens ne reconnaissant  
18 aucun plan à primes prépayées qui ne présente les  
19 conditions suivantes:

- 20 A. Possède une charte provinciale;
- 21 B. Assure la sécurité à la classe des  
22 citoyens à revenu minime, grâce à  
23 un plafond adéquat et la clause des  
24 médecins participants;
- 25 C. Assure des services couvrant  
26 non seulement l'hospitalisation  
27 et les services médico-chirurgicaux à  
28 l'hôpital, mais aussi à domicile et  
29 au bureau;
- 30





D. Distribue, exception faite des  
frais administratifs indispensables,  
tous les revenus des cotisations  
en prestations;

E. Comprenne un bureau médical  
efficace afin d'assurer aux  
abonnés des services médicaux de  
la plus haute qualité;

F. Assure des honoraires minima selon  
un barème établi par les Collèges  
des Médecins et Chirurgiens.

Voilà, madame et messieurs les commissaires,  
quelques-uns des points que se propose d'étudier, dans  
son mémoire, l'Association des médecins de langue  
française du Canada, et à ce stade, il me fait plaisir  
de céder la parole au docteur Wodehouse de  
l'Association canadienne.

LE PRESIDENT: Merci beaucoup, docteur Leger.







1 DR. WODEHOUSE: Mr. Chairman, my name is  
2 Wodehouse. I speak to you today on behalf of the  
3 Medical Profession in Canada in two capacities. First,  
4 as the honorary treasury of the Canadian Medical  
5 Association and secondly as chairman of the Executive  
6 Sub-Committee on Health Services of that Association.  
7 If I may continue where Dr. Leger left off sir.

8 25. The Canadian Medical Association is a  
9 federation of ten provincial divisions, each autonomous  
10 in its own sphere but combining to form the largest  
11 medical organization in this country. The Royal  
12 Commission will receive briefs and submissions from the  
13 provincial divisions of the C.M.A. and doubtless from  
14 other provincial medical organizations. It is  
15 unnecessary to elaborate that these provincial  
16 submissions will be of fundamental importance to the  
17 studies of the Commission because health in the  
18 Canadian context is primarily of provincial concern  
19 and because the health problems peculiar to our  
20 geographic regions will be reflected.

21 26. The functions of the C.M.A. are broadly covered  
22 by the following extract from the Act of Incorporation  
23 as amended in 1959:

24 "The objects of the Association shall be:

- 25 a) to promote the medical and related arts  
26 and sciences and to maintain the honour and  
27 the interests of the medical profession;  
28 b) to aid in the furtherance of measures  
29 designed to improve the public health and  
30 to prevent disease and disability;





- 1 c) to promote the improvement of  
2 medical services however rendered;  
3 d) to publish the Canadian Medical  
4 Association Journal and such other periodic  
5 journals as may be authorized, together  
6 with such transactions, reports, books,  
7 brochures or other papers as may  
8 promote the objects of The Association;  
9 e) to assist in the promotion of measures  
10 designed to improve standards of hospital  
11 and medical services;  
12 f) to promote the interests of the members  
13 of The Association and to act on their  
14 behalf in the promotion thereof;  
15 g) to grant sums of money out of the  
16 funds of The Association for the furtherance  
17 of these objects; and  
18 h) to do such other lawful things as are  
19 incidental or conducive to the attainment  
20 of the above objects."

21 27. As in most voluntary Associations, the work  
22 in the C.M.A. is carried out by committees which are  
23 as representative as possible of the regions of the  
24 country and of the gradations of professional opinion.

25 In our original submission you have a list  
26 of many of our committees, and with due respect sir,  
27 I know there is a request we do not mention these.

28 THE CHAIRMAN: You carry on as you see fit  
29 doctor.  
30







To indicate the range of our interests, the following partial list of committees is recorded:

- Advisory Committee to the Federal Government
- Committee on Approval of Hospitals for the Training of Junior Interns
- Committee on Approval of Schools for Laboratory Technologists
- Committee on Approval of Schools for Radiological Technicians
- Committee on Awards, Scholarships and Lectures
- Committee on Cancer
- Committee on Child Health
- Committee on Economics
- Committee on Ethics
- Committee on Hospital Service and Accreditation
- Committee on Occupational Medicine
- Committee on Maternal Welfare
- Committee on Medical Education
- Committee on the Medical Aspects of Traffic Accidents
- Committee on Nutrition
- Committee on Pharmacy
- Committee on Prepaid Medical Care
- Committee on Public Health
- Committee on Public Relations
- Committee on Rehabilitation

28. In addition to the large general medical Associations, the special and sectional interests of





1 the medical profession are represented by the following  
2 national medical societies all of which are affiliated  
3 with The Canadian Medical Association:

4 Canadian Academy of Allergy

5 Canadian Anaesthetists' Society

6 Canadian Association of Pathologists

7 Canadian Association of Physical Medicine  
8 and Rehabilitation

9 Canadian Dermatological Association

10 Canadian Heart Association

11 Canadian Medical Protective Association

12 Canadian Neurological Society

13 Canadian Ophthalmological Society

14 Canadian Orthopaedic Association

15 Canadian Otolaryngological Society

16 Canadian Paediatric Society

17 Medical Section of the Canadian Pharmaceutical  
18 Manufacturers' Association

19 Canadian Psychiatric Association

20 Canadian Rheumatism Association

21 Canadian Thoracic Society

22 Canadian Urological Association

23 College of General Practice of Canada

24 The Royal College of Physicians and Surgeons  
25 of Canada

26 Society of Obstetricians and Gynaecologists  
27 of Canada

28 The Canadian Association of Radiologists

29 The Canadian Life Insurance Medical Officers  
30 Association





29. It is our hope and expectation that many of them will elaborate for the Royal Commission on Health Services important matters in their fields of interest which may be mentioned only briefly in our own submissions.

30. In addition to the national medical societies affiliated with the C.M.A. there are certain organizations of mixed lay and medical membership devoted to the promotion of health in the special fields of their interest. The following is a list of such Canadian organizations which are affiliated with the C.M.A.:

Canadian Arthritis and Rheumatism Society

Canadian Association of Medical Record

Librarians

Canadian Cancer Society

Canadian Council for Crippled Children

and Adults

Canadian Mental Health Association

Canadian Nurses' Association

Canadian Tuberculosis Association

Health League of Canada

National Heart Foundation

Priory in Canada of the Grand Priory in the

British Realm of the Venerable Order of

the Hospital of St. John of Jerusalem.

The Canadian Diabetic Association

The Canadian Hearing Society

The Canadian Society of Laboratory

Technologists

Victorian Order of Nurses for Canada







31. The relationship of the medical profession to many other health agencies is intimate and cooperative and an interchange of representatives is carried out with the Association of Canadian Medical Colleges, the Canadian Hospital Association, the Canadian Red Cross Society and the National Cancer Institute of Canada. In the international sphere the C.M.A. is a member organization of the World Medical Association.

32. It may be inferred that the organization of the medical profession and the scientific developments of the last fifty years have enhanced the ability of doctors to provide more and better health services. The results are attested by the reduction in mortality and morbidity from a wide variety of diseases and in the steadily increasing span of life. Paradoxically, this has not resulted in a decrease but in a substantial increase in the demand for medical services. The care of a steadily increasing number of persons who are afflicted with chronic illnesses and with the physical and mental consequences of growing old presents a major problem. The provision of facilities and personnel to provide convalescent care and medical rehabilitation will assume greater importance than has been apparent in the past.

33. The increase in scientific knowledge has affected the whole structure of medical education and has accelerated the process of specialization. In a profession which demands a high standard of competence from its members, medicine has truly become a lifelong study so that the efforts of most of the organizations





1 of doctors are directed towards educational activities  
2 to enable their members to learn and to apply the  
3 new knowledge which is constantly becoming available.

4 34. Postgraduate education for purposes of  
5 licensure or approved specialist certification is  
6 provided in a carefully selected group of hospitals  
7 and medical centres. Continuing postgraduate  
8 education is available in the form of refresher courses,  
9 and at scientific sessions organized in conjunction with  
10 meetings of hospital staffs and of medical societies  
11 and associations varying from local to national in their  
12 scope. In addition, aids to education such as  
13 television, motion pictures, taped teaching material  
14 and scientific exhibits, are all used to refresh and  
15 improve the doctor's knowledge for the ultimate benefit  
16 of his patients.

17 35. Medical journals also play a very important  
18 part in the dissemination of scientific knowledge.  
19 The world's medical literature in the form of periodic  
20 publications has attained a volume and a quality which  
21 is quite astonishing. In Canada, the Canadian  
22 Medical Association Journal and l'Union Medicale du  
23 Canada are representative of the general medical  
24 journals publishing original work of Canadian  
25 authors. There are at least eight Canadian journals  
26 devoted to material in special fields of medicine and  
27 a host of reviews, bulletins, abstract journals and  
28 other publications all of which contribute substantially  
29 to the doctor's continuing education.

30 36. Good medical care, sir, in our opinion is







1 that ordinarily provided by the well-trained and  
2 conscientious physician. It is limited to the practice  
3 of rational medicine based on the medical sciences  
4 and the age-old arts of the profession. There is no  
5 place in good medical care for the quack, the cultist  
6 or the magician. In pursuit of its objective of  
7 "recommending methods of ensuring the best possible  
8 health care" the Royal Commission should not be  
9 diverted by the claims of the pseudo-scientific cults  
10 whose systems and theories are not represented in the  
11 curricula of any university or institution of higher  
12 learning.

13 37. The scope of publicly financed health services  
14 in Canada will doubtless impress the Royal Commission  
15 as its studies progress. Suffice it to say that we in  
16 Canada have accepted a large element of government  
17 participation in the provision of health services. In  
18 many instances these services were established at the  
19 instigation and urging of the medical profession and  
20 in all instances they are staffed by colleagues whom  
21 we undertake to represent. In the relatively restricted  
22 field of the federal authority it is worthy of mention  
23 that medical services are provided under the Department  
24 of Veterans' Affairs, the Department of National  
25 Defence and through the Department of National Health  
26 and Welfare. Divisions of the latter administer the  
27 Immigration and Sick Mariners' Medical Service and the  
28 Indian and Northern Health Services. The system of  
29 National Health grants, the very large contribution  
30 to hospital insurance and the recent substantial support





1 given to medical research through the Medical Research  
2 Council are examples of the application of tax dollars  
3 to our field of interest.

4 38. It is, however, in the realm of the provinces  
5 that the public financing of collective health services  
6 is seen in its fullest development. The whole  
7 field of public health, the mental health services, the  
8 control of tuberculosis and in some provinces the  
9 diagnosis and treatment of cancer, have been assumed.  
10 While the federal government makes very substantial  
11 monetary and other contributions to hospitalization  
12 insurance, the administration and a large portion of  
13 the cost have become provincial responsibilities.  
14 Measures to promote the rehabilitation of the sick  
15 and injured have been sponsored and supported. Further  
16 examples of the institutional care of whole segments  
17 of the population will also be seen in certain  
18 provinces.

19 39. Doctors have long recognized that patients  
20 should be able to budget for their expenditures on  
21 medical services in the same way as they budget for  
22 other essential needs. As a result, the medical  
23 profession of Canada has organized agencies for the  
24 application of insurance procedures to the distribution  
25 of medical services. As early as 1937 the first  
26 non-profit plans of prepaid medical care were  
27 established by the provincial divisions of the C.M.A.  
28 and today eleven such plans, organized, sponsored and  
29 fostered by the profession, provide medical services  
30 insurance to over four million Canadians. In the







1 immediate post-war period it was apparent that these  
2 plans of voluntary health insurance established under  
3 our auspices required to be organized nationally.  
4 A series of conferences called by the Canadian  
5 Medical Association resulted, in 1951, in the  
6 formation of Trans-Canada Medical Plans. The governing  
7 body of T.C.M.P. is representative of the Canadian  
8 Medical Association and the following member plans,  
9 all of which are sponsored by the profession, and  
10 provide medical services insurance primarily in the  
11 provinces indicated:

12 Maritime Medical Care Incorporated

13 (Nova Scotia)

14 Maritime Hospital Service Association

15 (New Brunswick, Prince Edward Island,  
16 Newfoundland).

17 Quebec Hospital Service Association (Quebec)

18 Physicians' Services Incorporated (Ontario)

19 Windsor Medical Services, Incorporated  
20 (Ontario)

21 Manitoba Medical Service (Manitoba)

22 Medical Services Incorporated (Saskatchewan)

23 Group Medical Services (Saskatchewan)

24 Medical Services (Alberta) Incorporated  
25 (Alberta)

26 Medical Services Association (British  
27 Columbia)

28 B.C. Medical Services Incorporated  
29 (British Columbia).

30 40. In addition to the plans of prepaid medical







1 care established under our own auspices, a variety  
2 of organizations, chiefly the licensed insurance  
3 companies of Canada also provide insurance coverage  
4 to a further four million Canadians. We have worked  
5 closely with these agencies and in the process have  
6 gained a knowledge of the merits of their approach to  
7 a common problem.

8 41. Similarly, the profession has since 1935 co-  
9 operated with provincial governments in the provision  
10 of medical care to the recipients of public assistance.  
11 Such plans, basically financed with public funds but  
12 heavily subsidized by the profession, now operate in  
13 British Columbia, Alberta, Saskatchewan, Manitoba,  
14 Ontario and Nova Scotia.

15 42. The experience of the doctors of Canada  
16 in cooperating with governments in the provision of  
17 health services and their participation in medical  
18 insurance plans of all types has led to certain  
19 conclusions which were expressed in June, 1960  
20 in the following C.M.A. Statement on Medical Services  
21 Insurance which has subsequently been endorsed by  
22 I.A.M.L.F.C. and thus represents the collective  
23 viewpoint of the medical profession of Canada:

24 "The Canadian Medical Association believes  
25 that:

26 The highest standard of medical services  
27 should be available to every resident  
28 of Canada

29 Insurance to prepay the costs of medical  
30 services should be available to all





1 regardless of age, state of health or  
2 financial status.

3 Certain individuals require assistance  
4 to pay medical services insurance costs.  
5 The efforts of organized medicine,  
6 governments and all other interested  
7 bodies should be coordinated towards  
8 these ends.

9 While there are certain aspects of  
10 medical services in which tax-supported  
11 programs are necessary, a tax-supported  
12 comprehensive program, compulsory for  
13 all, is neither necessary nor desirable.

14 However sir the Canadian Medical Association  
15 is further on record as follows:

16 43. The Canadian Medical Association will  
17 support any program of medical services insurance which  
18 adheres to the following principles:

- 19 1. That all persons rendering services  
20 are legally qualified physicians  
21 and surgeons.
- 22 2. That every resident of Canada is free  
23 to select his doctor and that each  
24 doctor is free to choose his patients.
- 25 3. That the competence and ability of any  
26 doctor is determined only by professional  
27 self-government.
- 28 4. That within his competence, each  
29 physician has the privilege to treat  
30 his patients in and out of hospital.







5. That each individual physician is free to select the type and location of his practice.
6. That each patient has the right to have all information pertaining to his medical condition kept confidential except where the public interest is paramount.
7. That the duty of the physician to his individual patient takes precedence over his obligations to any medical services insurance programs.
8. That every resident of Canada, whether a recipient or provider of services, has the right of recourse to the courts in all disputes.
9. That medical services insurance programs do not in any way preclude the private practice of medicine.
10. That medical research, undergraduate and postgraduate teaching are not inhibited by any medical services insurance program.
11. That the administration and finances of medical services insurance programs are completely separate from other programs, and that any board, commission or agency set up to administer any medical services insurance program has fiscal authority and autonomy.





12. That the composite opinion of the appropriate body of the medical profession is considered and the medical profession adequately represented on any board, commission or agency set up to plan, to establish policy or to direct administration for any medical services insurance program.

13. That members of the medical profession, as the providers of medical services, have the right to determine the method of their remuneration.

14. That the amount of remuneration is a matter for negotiation between the physician and his patient, or those acting on their behalf; and, that all medical services programs make provision for periodic or automatic changes in remuneration to reflect changes in economic conditions."

44. The foregoing description of the medical profession of Canada in general terms is designed to acquaint the Royal Commission on Health Services with certain characteristics of the doctors' part in health services and to establish our right to speak for the profession.

45. It should be apparent that the physician performs a function which is socially useful and which has as its central motive his obligation to promote the





1 welfare of the patient. Doctors as individuals and  
2 as citizens have certain rights which should be  
3 recognized and preserved. These include the right  
4 to organize for his own protection and for the  
5 promotion of his interest; the right to exercise  
6 freedom of choice with respect to the type of work  
7 which he undertakes and the location in which he  
8 performs it; the right to accept or reject individual  
9 patients subject only to emergent and humanitarian  
10 considerations; the right to participate in or abstain  
11 from any plan of medical services insurance; the right  
12 to determine the method of his remuneration and,  
13 subject to the controls imposed by law and by his  
14 colleagues, to manage all aspects of his patients'  
15 disabilities within his competence.

16 46. The medical profession is aware that in  
17 addition to the rights here mentioned the doctor has  
18 an obligation to keep his knowledge in good repair,  
19 to bring to the service of his patient his undivided  
20 attention and his best efforts, to seek the aid of  
21 colleagues when the patient's condition demands skills  
22 beyond his capacity and experience and, in general,  
23 strive to apply with kindness and humanity all the  
24 resources of his profession for the well-being of his  
25 patient.

26 47. As stated at the outset, Mr. Chairman, this is  
27 a preliminary general submission of the medical  
28 profession. We will file further specific data and  
29 recommendations as the studies of the Royal Commission  
30 on Health Services proceed.







1 THE CHAIRMAN: Now Dr. Wodehouse and Dr.  
2 Kelly and Dr. Leger and those organizations for whom  
3 you have spoken here today, I think it is perhaps  
4 desirable that I should say that we recognize that the  
5 submissions read by Dr. Leger and Dr. Wodehouse do  
6 go beyond what we, in a sense, expected from  
7 contributors to the program today, but it is not  
8 unexpected because we did encourage the two  
9 Associations to make this statement of their principles  
10 so that all others who might later at public hearings  
11 be presenting briefs would do so with full knowledge  
12 of the position being taken by the Medical Association  
13 and their affiliates and naturally might wish to  
14 have this knowledge in the preparation of their own  
15 briefs and submissions.

16 I think perhaps I should say also that, as  
17 I mentioned in a question I put to Dr. Kelly as to  
18 whether submissions would later be made covering the  
19 various items, that we expect will apply to the  
20 recommendations made by Dr. Leger and by Dr. Wodehouse,  
21 I put it this way: for myself I don't know that I  
22 understood completely all the implications involved.  
23 There would necessarily have to be amplification of many  
24 perhaps by some questions by individual commissioners  
25 but it is not the purpose of this hearing today to  
26 explore into those avenues or those areas and we  
27 are looking forward to having from the two Associations  
28 represented here today further and more elaborate  
29 briefs at whatever public hearings the Associations  
30 may chose to make them and at a time when the entire





1 implication of all that has been said may be  
2 explored as fully as anyone might wish to do so.

3 DR. KELLY: I might comment sir on the  
4 desirability of circulating this material to other  
5 interested organizations. We plan to put in the  
6 Saturday issue of the Canadian Medical Association  
7 Journal the two documents which we have placed before  
8 you today and we would be glad to give any other  
9 interested organizations mimeographed copies.

10 THE CHAIRMAN: Thank you very much, Dr. Kelly.  
11 As you will appreciate, the submissions made today  
12 have become part of the record of this Commission and  
13 are available to all or to anyone who may wish to obtain  
14 a copy from the reporting firm as I indicated at the  
15 opening this morning. The next one, Mr. Lafrance?

16 THE SECRETARY: School of Hygiene, Univeristy  
17 of Toronto.

18 DR. RHODES: Mr. Chairman, Members of the  
19 Commission, this is a very great privilege indeed to  
20 have this opportunity of addressing you and the group  
21 that I represent has perhaps three particular  
22 qualifications for making a submission to you today.

23 The University of Toronto has fifty years  
24 of experience in graduate education in Public Health.  
25 A course leading to the Diploma in Public Health having  
26 been first offered by the Department of Hygiene and  
27 Preventative Medicine in 1912. Since the establishment  
28 of the School of Hygiene as an independent division of  
29 the university in 1927, the program of graduate education  
30 has been steadily expanded. At present, the school







1 provides instruction in public health subjects to  
2 over 100 graduates each year, through courses offered  
3 to physicians, dentists, veterinarians, engineers,  
4 laboratory scientists, nutritionists, administrators,  
5 graduates in business, and health educators. These  
6 courses offer instruction in the specialties of Public  
7 Health, Industrial Health, Microbiology, Nutrition,  
8 Hospital Administration, Veterinary Public Health,  
9 Dental Public Health, and Health Education.

10 Undergraduate students in medicine, nursing,  
11 pharmacy, arts, household science, and physical and  
12 health education also take courses from the staff of the  
13 School of Hygiene.

14 An extensive program of research in the basic  
15 public health sciences, in the administration of health  
16 services, and in certain aspects of professional  
17 education is carried out. References to four studies,  
18 which may be of interest to the Commission, are given  
19 in the appendix. These studies relate to the work  
20 and education of the Canadian general (medical)  
21 practitioner, to the work of the Medical Officer of Health  
22 in Canada, to graduate education in hospital  
23 administration, and to the administration of health  
24 services and health "insurance" programs in certain  
25 European and Asian countries.

26 In addition, the services of staff members  
27 of the school are from time to time requested by  
28 various branches of government and by voluntary health  
29 agencies. For example, Dr. Milton H. Brown, Professor  
30 of Public Health and Preventative Medicine in the





1 school, is at present undertaking a detailed study  
2 of the programs of the Department of Health for Nova  
3 Scotia.

4 The above information is given to indicate  
5 the particular interest of the School of Hygiene in the  
6 whole field of health services, and to make it clear  
7 to the Royal Commission on Health Services that the  
8 services of the staff are available for further  
9 inquiries, subject to the limitations imposed by  
10 teaching and other obligations to the University of  
11 Toronto.

12 Present-day Concepts of the Role of Public Health

13 Public Health is a branch of medical and  
14 scientific work that has the objectives of protecting,  
15 maintaining and improving the health of people in a  
16 social unit, whether it be a whole country, a province,  
17 a local community, or even a group of workers in a  
18 factory.

19 Preventive measures used by public health  
20 workers include the supervision of environmental  
21 factors that influence health, such as, water and food,  
22 the atmosphere, radiation, housing, and working  
23 conditions. Other preventive measures include the  
24 maintenance of adequate nutrition, the prevention and  
25 control of infectious diseases, the promotion of  
26 mental health, and the prevention of accidents. The  
27 maintenance of diagnostic laboratories, especially in  
28 the field of bacteriology and virology, is a vital  
29 function of public health agencies.

30 Certain therapeutic measures, when provided on







1 a community basis, also come within the scope of  
2 interest of public health, such as diagnostic services,  
3 treatment services, rehabilitation services, home care  
4 services, nursing home and convalescent services,  
5 chronic disease services, services for children,  
6 services for occupational groups, and services  
7 for the aged. Physicians and others trained in public  
8 health are being called upon increasingly to plan  
9 and administer health services, including the provision  
10 of hospital care and plans providing the personal  
11 services of physicians.

12 It will be evident therefore that the scope  
13 of public health in Canada today encompasses all  
14 matters that may affect the health of the Canadian  
15 people. There is probably no other group of  
16 professionally trained workers in Canada who have  
17 this breadth of outlook and of interest.

18 The new concept of public health, and of the  
19 role of public health workers, is expressed in the  
20 preamble to the Constitution of the World Health  
21 Organization of which Canada is a founding member.  
22 In part, the preamble states:

23 "Health is a state of complete  
24 physical, mental, and social well-  
25 being and not merely the absence of  
26 disease or infirmity.

27 The enjoyment of the highest  
28 attainable standard of health is one  
29 of the fundamental rights of every  
30 human being without distinction of race







1 religion, political belief, economic  
2 or social condition.

3 Governments have a responsibility  
4 for the health of their peoples which  
5 can be fulfilled only by the provisions  
6 of adequate health and social measures."

7 It is because of a wide concern in all  
8 matters affecting the health of the Canadian people  
9 and in undergraduate and graduate education in the  
10 health fields that the School of Hygiene wishes to  
11 make certain suggestions in this initial submission  
12 to the Royal Commission on Health Services. It is  
13 realized that the Royal Commission will receive numerous  
14 other submissions. Therefore, attention is focussed  
15 on topics of particular interest to an academic group  
16 charged with the task of training health workers and  
17 in carrying out research studies of community health  
18 services.

19 Some Problems Requiring Investigation by  
20 the Royal Commission

21 1. Measurement of Health Status

22 At the moment, it is difficult to compare  
23 the health status of Canadians with citizens of  
24 other "developed" countries of an approximately similar  
25 social and economic level. Certain vital statistics  
26 are customarily used for comparison. In some statistics,  
27 Canada ranks below certain other countries, such as the  
28 Netherlands, Scandinavian countries, New Zealand, and  
29 the United Kingdom.

30 (a) The School of Hygiene recommends that an





1 examination of the value of existing "indicators" of  
2 health and an exploration of the possible development  
3 and use of new "indicators" be made. (It is only  
4 when accurate "yard sticks" of health are available,  
5 that the true picture in Canada, in each province,  
6 and in different parts of individual provinces  
7 can be assessed and that an accurate baseline can  
8 be established for subsequent periodic assessment  
9 of programs.)

10 (b) The School of Hygiene recommends that a study be  
11 made of existing vital statistics services in the  
12 provinces and in the Dominion Government to see if  
13 improvements are indicated.

## 14 II. Evaluation of Quality of Practice of Professional 15 Health Workers

16 Perhaps the most important feature of any  
17 service rendered by a physician, dentist, nurse and  
18 other professional workers is that it should be as  
19 good as possible.

20 Quality of service depends to some extent  
21 on the standards required of professional workers before  
22 they are allowed to practice, and to some extent,  
23 on the degree to which they are able to improve and  
24 keep their knowledge up-to-date after graduation.

25 (a) The School of Hygiene recommends that  
26 the Royal Commission collect and study  
27 details of the various licensing requirements  
28 for physicians and other professional  
29 health workers.

30 (b) The School of Hygiene recommends that







1 study be made of the various means of  
2 acquiring specialty status, such as the  
3 programs of the Royal College of Physicians  
4 and Surgeons of Canada and the graduate  
5 training programs of Medical Schools  
6 and Schools of Hygiene.

7 (c) The School of Hygiene recommends  
8 study of various programs designed  
9 to assist professionally qualified  
10 people to keep up-to-date. An important  
11 component of this study would be a  
12 review of postgraduate teaching facilities  
13 in public health, as well as in the  
14 other branches of professional health  
15 work.

16 (d) The mechanism of independent  
17 evaluation or "Accreditation" using  
18 objective standards is accepted by  
19 educational institutions and hospitals  
20 as a stimulus to high quality.  
21 Accordingly, the School of Hygiene  
22 recommends that study be made of the  
23 possible application of similar  
24 techniques as stimuli to quality in  
25 the work done by individual health  
26 workers and groups of health workers.





L/dpw 1 III. Evaluation of Quality of Programmes of Official and  
2 Voluntary Health Agencies

3 Health programmes of official and non-govern-  
4 ment agencies, when begun, usually have clearly defined  
5 objectives and a policy to help attain these objectives.  
6 However, such programmes often are continued for a long  
7 time without a critical evaluation of their effectiveness.

8 (a) The School of Hygiene recommends that  
9 a study be made of techniques of programme  
10 evaluation, such as those conducted in the  
11 New York State Department of Health and  
12 elsewhere to determine their suitability in  
13 the Canadian scene.

14 (b) The School of Hygiene recommends that  
15 attention be paid to the need for periodic  
16 independent and objective evaluations of  
17 the programmes of voluntary Health Agencies.

18 IV. Availability of Health Services

19 Inequalities and deficiencies in the ready  
20 and adequate availability of health workers and health  
21 services exist among and within the different regions of  
22 Canada.

23 (a) The School of Hygiene recommends that  
24 studies be undertaken to determine the needs  
25 for the different professional and non-  
26 professional workers, to determine the  
27 problems of recruitment to these fields,  
28 and to try to find ways for alleviating the  
29 shortages and inequalities.

30 (b) The School of Hygiene recommends that





1 studies be undertaken to determine the  
2 deficiencies in the various health services,  
3 such as public health services, diagnostic  
4 and laboratory services, treatment services,  
5 convalescent and rehabilitation services,  
6 services for the chronically ill, services  
7 for the aged, and social services directly  
8 related to health, and to try to find ways  
9 for alleviating the deficiencies.

10 V. Professional Education and Non-Professional Training

11 Without well-educated professional and well-  
12 trained non-professional workers modern health services  
13 cannot be provided.

14 (a) The School of Hygiene recommends that  
15 studies be made of the present activities  
16 of professional health workers, of possible  
17 ways for allowing their more efficient use,  
18 and of possible improvements in the under-  
19 graduate, graduate, and post-graduate educa-  
20 tion of all types of professional health  
21 workers.

22 (b) The School of Hygiene recommends that  
23 studies be made of the present use and  
24 training of all types of non-professional,  
25 para-medical health workers and of possible  
26 ways for using their skills more effectively.

27 VI. Co-ordination of Local Health Services

28 The present pattern of health services in  
29 Canada, especially in the larger centres, resembles a  
30 patch-work quilt. Services may be available in any one







1 area from an agency of the Dominion Government, from  
2 provincial government departments, from municipal govern-  
3 ment, from hospitals and clinics, from voluntary health  
4 organizations, from charitable organizations, and from  
5 different types of private health workers. It is almost  
6 impossible both for those receiving service and also for  
7 those providing it to know the details of all the services  
8 available.

9 (a) The School of Hygiene recommends that  
10 the need for a co-ordinator of health  
11 services in each area and the possible role  
12 of the local Medical Officer of Health in  
13 this capacity be studied.

14 VII. Co-ordination of Health Services at the Provincial  
15 Level

16 (a) The School of Hygiene recommends that  
17 study be made of the possible establishment  
18 in each province of a Provincial Advisory  
19 Committee on Health Services composed of  
20 leading people who could give reasoned and  
21 unbiased advice to the provincial government  
22 and to non-government organizations about  
23 general health policy and the planning of  
24 health services. Such a body could exert  
25 a beneficial influence by recommending new  
26 services when indicated and by recommending  
27 that unsuitable proposals be dropped.

28 VIII. Comparative Studies of Health Services in Other  
29 Countries

30 Over the years the Department of National





1 Health and Welfare has made regular, valuable studies of  
2 the health service patterns in other countries. Other  
3 qualified groups and individuals, including members of  
4 the staff of the School of Hygiene, have also carried out  
5 detailed studies of this type. It would seem of little  
6 value to repeat these studies since detailed information  
7 is available already.

8 (a) The School of Hygiene recommends that  
9 following the detailed studies of the many  
10 aspects of providing health services in  
11 Canada, specific studies be undertaken of  
12 particular aspects of foreign programmes  
13 which could provide useful experience for  
14 planning in Canada.

15 In Summary

16 In the light of its responsibility for the  
17 training of undergraduates and graduates in Public Health  
18 and of its knowledge of the health services in Canada as  
19 presently available, the School of Hygiene, University of  
20 Toronto, recommends that the Royal Commission on Health  
21 Services pay particular attention to the following:

- 22 1. Methods for the measurement of health  
23 status.
- 24 2. Methods for evaluating the quality of  
25 practice of professional health workers.
- 26 3. Methods for evaluating the quality of  
27 programmes of official and voluntary health  
28 agencies.
- 29 4. Methods for removing inequalities and  
30 deficiencies in the availability of health







workers and different health services.

5. Methods for improving the education, training, and use of professional and non-professional health workers.

6. Methods to improve the co-ordination of local health services.

7. Methods to improve the co-ordination of health services at the provincial level.

8. Comparative studies of specific aspects of health services in other countries following the detailed studies of providing health services in Canada.

#### APPENDIX

#### Recent Studies of Staff Members, School of Hygiene, University of Toronto in the Fields of Medical Education and Health Services Administration

##### 1. Clute, Kenneth, F. "A Survey of the Work of General Practitioners in Ontario and Nova Scotia"

For the last  $5\frac{1}{2}$  years, Dr. K.F. Clute has been making an intensive study of the work of a "random sample" of 86 general practitioners in Ontario and Nova Scotia. Dr. Clute's study has been conducted with the support of the College of General Practice of Canada, and has been financed by the Rockefeller Foundation, the Canadian Life Insurance Officers Association, and the Canadian Federal-Provincial Health Grants Programme.

Dr. Clute's report will be published by the University of Toronto Press in 1962. It is proposed to submit a copy of this book to the Commission, with





1 attention drawn to pertinent passages.

2           This study is unique, not only in Canada  
3 but in any other country, in its thoroughness. The  
4 author describes in detail the day to day work of the  
5 physician, the types of case he sees, the diagnostic and  
6 therapeutic problems involved, and the quality of medicine  
7 practised, and discusses at length the implications of  
8 his findings as far as medical education and the organiza-  
9 tion of medical care are concerned.

10 2. le Riche, W. Harding. "A Survey of the Work of the  
11 Medical Officer of Health in Canada"

12           With the co-operation of Dr. E.W.R. Best of  
13 the Department of National Health and Welfare, Dr. le Riche  
14 is just completing the analysis of the work of almost all  
15 of the full time physicians holding the public office of  
16 Medical Officer of Health or Medical Health Officer in  
17 eight of the ten Provinces (Quebec has not yet been  
18 surveyed. Newfoundland has a different administrative  
19 system).

20           This is the first time that such a detailed  
21 study has been done in Canada. The study has been  
22 financed by the W.K. Kellogg Foundation, Battle Creek,  
23 Michigan.

24           Arising out of this study, and in part as  
25 an independent inquiry, Dr. le Riche is preparing a mono-  
26 graph on "Graduate Education in Public Health".

27           It is anticipated that the reports of both  
28 these studies by Dr. le Riche in whole or in summary form,  
29 will form part of the brief to be submitted to the Royal  
30 Commission on Health Services, at a later date.







3. McLaren, Kenneth S. "A Study of Graduate Education in  
Hospital Administration"

Mr. McLaren, formerly Assistant Professor, Department of Hospital Administration, School of Hygiene, has recently submitted to the W.K. Kellogg Foundation, a very detailed study and critique of graduate education for hospital administrators. This report, or portions thereof, can also be made available.

4. Hastings, J.E.F. "A Report to the World Health Organization on Health Services in Selected Countries"

Dr. Hastings is completing a report of a lengthy tour under World Health Organization auspices of the United Kingdom, Norway, Denmark, Sweden, the Union of Soviet Socialist Republics, India, Ceylon, and Japan, during which he studied the organization and administration of their health services and health "insurance" programmes. Lessons applicable to the Canadian scene are stressed. Subject to the approval of the World Health Organization, this report can be made available when completed.

That, Mr. Chairman, members of the Commission, completes the suggestions from our group at the University of Toronto.

THE CHAIRMAN: Dr. Rhodes, I think I would like to put substantially the same question to you as I did to the speakers from the Canadian Medical Association and the other association. You have made a number of recommendations as to areas of study. We are assuming that the School of Hygiene will be tendering a formal brief or submission at some time during the hearings. At







1 that time will the School of Hygiene also seek to give the  
2 answers to some of these propositions they have raised  
3 and areas they think require study and improvement.

4 DR. RHODES: Yes, Mr. Chairman, they  
5 certainly will. Unfortunately, however, in certain areas  
6 special studies will be required because information is  
7 not readily available at the moment. That is why some of  
8 these matters were raised today.

9 THE CHAIRMAN: Naturally within the  
10 resources of the School of Hygiene.

11 DR. RHODES: Yes.

12 THE CHAIRMAN: Thank you very much, Dr.  
13 Rhodes.

14 THE SECRETARY: The Canadian Public Health  
15 Association.

16 DR. RHODES: Mr. Chairman and members of  
17 the Commission, on this day I am wearing two hats, and  
18 prefer not to wear any hat at all.

19 Mr. Chairman, members of the Commission, I  
20 appear at this second time, and I am grateful for this  
21 privilege, on behalf of the Canadian Public Health Associa-  
22 tion mainly because the President is not here. I happen  
23 to be Vice-President of the Association.

24 The Canadian Public Health Association is a  
25 national organization with eight provincial branches or  
26 affiliated associations. For over fifty years, it has  
27 been concerned with the conservation and improvement of  
28 the health of the people of Canada. Its members belong  
29 to all the disciplines concerned with the health of the  
30 people of Canada and include physicians, dentists,





1 veterinarians, engineers, laboratory scientists, nurses,  
2 statisticians, health educators, sanitary inspectors and  
3 others. Among its members it numbers persons engaged in  
4 official health agencies at all levels of government, as  
5 well as professional and technical persons who are engaged  
6 in the broad area of health services, plus - and this is  
7 an interesting feature - a number of interested lay people  
8 who are concerned with the general health and well-being  
9 of the public. In 1960, the Government of Canada granted  
10 it a new Charter which states that "The objects of the  
11 Association shall be the development and diffusion through-  
12 out Canada of the knowledge of public health and preventive  
13 medicine and all other matters and things appertaining  
14 thereto, or connected therewith".

15           This broad definition is in keeping with the  
16 changing concepts of public health. During the lifetime  
17 of the Association great progress has been made in the  
18 traditional areas of public health such as the control of  
19 communicable diseases and the management of a sanitary  
20 environment. The Association feels that it has a much  
21 wider interest than the areas usually associated with  
22 public health and that it has a vital interest in all  
23 matters which concern the health of the people of Canada  
24 including prevention, treatment and rehabilitation.

25           It is obvious that a primary concern of each  
26 of our citizens should be to maintain the highest possible  
27 state of health. This state of good health occurs when  
28 the numerous factors concerned with the maintenance of  
29 this condition predominate. For many reasons, however,  
30 the balance in favour of a state of good health is upset







1 and disease occurs. This struggle between the factors  
2 which maintain health and those which produce disease is  
3 continuous. When preventive measures fail and disease  
4 does occur, every effort must be made to restore the  
5 individual to a state of good health by means of adequate  
6 treatment and provision of facilities necessary for his  
7 rehabilitation.

8           It is suggested that health services can  
9 best be studied by considering three main features,  
10 namely quality, availability and effective use and co-or-  
11 dination. It is difficult, admittedly, to provide objec-  
12 tive tools for the measurement of these desirable elements  
13 of health services. It is suggested, however, that  
14 although certain indices are available at the present time,  
15 others need to be developed. It seems reasonable to  
16 suggest that the Commission examine existing indices,  
17 improve them where possible, and even develop new ones.

#### 18 Quality of Care

19           With regard to the first feature to be  
20 evaluated, namely, the quality of health care in Canada,  
21 there seems to be a generally accepted assumption that  
22 Canadian health care is as good as any in the world.  
23 While this assumption may be true, there is a lack of  
24 objective studies in this area. It is, therefore,  
25 suggested that this assumption may have been made on  
26 insufficient evidence and may not necessarily be true.  
27 Further, this assumption may be valid in certain parts of  
28 Canada or for certain groups of the population, but not  
29 for others.

30           As was noted, the problem of measuring any





1 aspect of health care is difficult. One measurement  
2 would be to make comparisons with other jurisdictions.  
3 To do this, comparable indices are necessary. Some of  
4 these are available such as infant mortality rates,  
5 maternal mortality rates, crude and specific death rates  
6 plus a limited amount of information on rates of incidence  
7 and prevalence of disease and volume of disability.  
8 Based on the latest available data, Canada's rank among  
9 countries of the world - first rank being the country  
10 with the lowest mortality rate - is as follows:

11 Deaths from motor vehicle accidents - 15th;

12 Deaths from all other accidents - 15th;

13 Deaths from heart diseases - 13th;

14 Infant mortality - 12th;

15 Maternal mortality - 9th;

16 Mortality from infective and parasitic  
17 diseases - 3rd.

18 The Association recommends, therefore, that  
19 the Commission undertake much more detailed studies than  
20 have been done in Canada with a view to assessing where  
21 we stand in terms of the quality of health care being  
22 provided in Canada. Additionally, such a study should  
23 encourage further comparison as well as establishing a  
24 base line for the evaluation of future progress.

25 Availability of Care

26 The second characteristic requiring study  
27 is the availability of health services. Modern concepts  
28 recognize that many health services are required in  
29 effectively handling the continuous process of maintaining  
30 health and restoring those who become ill to a state of







1 health.

2 It is useful to identify some of these  
3 services.

4 Prevention - This is a major interest of  
5 public health and includes immunization,  
6 control of communicable diseases, and the  
7 maintenance of a healthful environment.

8 Diagnosis - This means the accurate identi-  
9 fication of disease in the earliest stage  
10 of its development.

11 Treatment - This means adequate treatment  
12 with the objective of restoration to a  
13 state of health.

14 Rehabilitation - This has physical, psycho-  
15 logical and social elements. Modern  
16 concepts include availability of prosthetic  
17 devices, vocational guidance, retraining  
18 and placement.

19 The Association recommends that the Commis-  
20 sion undertake studies of the availability and adequacy  
21 of health services. It is also suggested that considera-  
22 tion should be given as to the reasons why some persons  
23 fail to avail themselves of services which are provided.

24 Effective Use and Co-ordination

25 The third feature of health services for  
26 consideration is their effective use and co-ordination.  
27 It is felt that the Commission should put major emphasis  
28 on how all these diverse resources required to maintain  
29 the balance in favour of health may be most effectively  
30 used.







1                   The Commission will also wish to study the  
2 need for co-ordination of the health services provided by  
3 the various agencies. It appears that too many people  
4 fail to obtain required services because of the lack of  
5 this essential co-ordination.

6 Summary

7                   In accordance with the above thoughts, our  
8 Association recommends that the Commission develop better  
9 and more effective indices for the evaluation of health  
10 services and that it undertake studies of the quality,  
11 availability, effective use and co-ordination of health  
12 services.

13                   If the Commission decides to establish  
14 groups of technical experts to study health services  
15 from the point of view suggested by the Association, or  
16 from any other point of view, the Commission may be  
17 assured that members of the Canadian Public Health Associa-  
18 tion will be prepared to co-operate to the fullest extent.

19                   The Commission may feel that there is a need  
20 for a background document on Public Health in Canada  
21 describing its growth, its scope and its trends. The  
22 Association would be happy to assist in this work.

23                   The Association asks me to make it plain to  
24 you that if a background document on public health in  
25 this country is required they are prepared to undertake  
26 this task, and if the Association can assist in any way,  
27 then you have only to ask.

28                   THE CHAIRMAN: Thank you very much, Dr.  
29 Rhodes.





1 THE SECRETARY: The Canadian Pharmaceutical  
2 Association.

3 PROF. J.L. SUMMERS: Mr. Chairman, members  
4 of the Commission, my name is J.L. Summers, of the  
5 University Hospital, Saskatchewan, Chairman of the  
6 Health Matters Studies Committee of the Canadian  
7 Pharmaceutical Association. I am supported in this  
8 preliminary this afternoon by Mr. D.R. Mitchell, M.P.,  
9 President, and Mr. John C. Turnbull, Secretary of the  
10 Association.

11 Introduction

12 1. This preliminary statement is respectfully  
13 submitted to the Royal Commission on Health Services  
14 by the Canadian Pharmaceutical Association. This  
15 Association, founded in 1907 and incorporated by Charter  
16 in 1923, is a federation of provincial statutory  
17 pharmacy bodies and its Council also includes  
18 representation by several specialized pharmacy  
19 organizations having Canada-wide membership. All  
20 pharmacists who are licensed to practise their  
21 profession in a Canadian province are members of the  
22 Association by virtue of their registration in their  
23 provincial statutory pharmacy organizations. Membership,  
24 presently numbering 8,940, therefore embraces pharmacists  
25 in retail, both owners and employees, hospital, teaching,  
26 industry, government and armed services, and other  
27 endeavours related to the research, production and  
28 distribution of drugs. An explanatory statement on  
29 Canadian pharmaceutical organizations is attached  
30 as Appendix A which briefly describes the various







1 organizations and their relationship to the Canadian  
2 Pharmaceutical Association. It was felt that this  
3 information would be of value to the Commission as they  
4 hear from other organizations across Canada.

5 2. To effect a measure of agreement on terminology  
6 a definition of "pharmacy" and "pharmacist" is attached  
7 to this statement as Appendix B. You may think is  
8 a bit odd. We have already participated in four different  
9 Commissions, committees, investigations and hearings  
10 this year, and the extent to which these terms have  
11 been misused and misunderstood we feel that there  
12 should be a greater precision of the use of these  
13 terms, and we have attempted to define them for your  
14 guidance and also for the guidance of others who  
15 have used them in submitting briefs on this subject.

16 Aims

17 3. The aims of this preliminary statement are:

18 (a) To state the intention of the Canadian  
19 Pharmaceutical Association of presenting  
20 a submission to the Commission at its  
21 regular public hearing in Ottawa in March  
22 1962, and at such other regular  
23 times deemed advisable and/or at the  
24 request of the Commission.

25 (b) To state that official representatives  
26 of the Canadian Pharmaceutical Association  
27 will attend the Preliminary Hearing of  
28 the Commission in Ottawa, September 27,  
29 1961.

30 (c) To present the views of the Canadian





1                   Pharmaceutical Association as to the  
2                   areas and problems pertaining to pharmacy  
3                   which should be covered by the Commission  
4                   in its investigations and/or deliberations.

5   Suggested Areas and Problems Pertaining to Pharmacy

6   4.           The areas and problems suggested are those which  
7           the Canadian Pharmaceutical Association believes will  
8           yield the most significant information to the  
9           Commission, and these this Association will be prepared  
10          to submit in its brief in all of these areas. It is  
11          realized that other organizations and individuals  
12          may suggest additional pharmacy problems of interest  
13          and importance. Indeed, it is hoped that they will do  
14          so.

15   5.           The suggested areas of study are set out in  
16          the following paragraphs in a broad outline which refers  
17          to the specific terms of reference stated in the Order-  
18          in-Council P.C. 1961-883. An elaboration providing  
19          additional details of this outline is attached as  
20          Appendix C.

21   6. Problems falling under the term of reference (a)

22          6.1 The scope of professional responsibility  
23          of pharmacy.

24          6.2 Present methods of providing drugs and  
25          pharmaceutical services.

26   7. Problems and areas within the term of reference (b)

27          7.1 Quantitative and qualitative  
28          deficiencies in present methods of providing  
29          drugs and pharmaceutical services.

30          7.2 Improvements and extensions of service







1 to remedy deficiencies.

2 8. Areas of study within term of reference (c)

3 8.1. Methods of effecting improvements and  
4 extensions of pharmaceutical services.

5 8.2 Effects of implementing improvements  
6 and extensions of present methods of  
7 providing drugs and pharmaceutical services.

8 9. Problems presented under term of reference (d)

9 9.1 Present manpower status and requirements  
10 for professional pharmaceutical services  
11 in all areas of pharmacy including retail,  
12 hospital, industry, teaching, research  
13 and government service.

14 9.2 Present utilization of professional  
15 services of available pharmacists.

16 9.3 Probable effect on pharmacy manpower  
17 requirements by increases in population,  
18 developments in drug therapy and  
19 requirements for possible extended services.

20 10. Areas of study under term of reference (e)

21 10.1 The recruitment of able students  
22 into pharmacy.

23 10.2 The provision of adequate teaching  
24 facilities offering high quality programs  
25 of training.

26 10.3 The development of a program of  
27 continuation training for pharmacy  
28 practitioners.

29 11. Problems for consideration under term of reference(f)

30 11.1 The present physical facilities







1 for providing drugs and pharmaceutical  
2 services to the general public and  
3 their quantitative and qualitative adequacy.

4 11.2 The development of a ratio of  
5 facilities to population that will  
6 ensure an adequate standard of pharmaceutical  
7 service.

8 11.3 Present physical facilities for  
9 providing adequate pharmaceutical services  
10 in hospitals.

11 11.4 Future requirements for hospital  
12 and retail pharmacy facilities.

13 11.5 Present and future requirements for  
14 physical facilities for pharmaceutical research  
15 and education.

16 12. Areas of study under term of reference (g)

17 12.1 Types of drugs, medicinal preparations  
18 and therapeutic devices considered essential  
19 to the provision of quality health care.

20 12.2 The present cost of providing the  
21 drugs and pharmaceutical services  
22 considered necessary under study 12.1

23 12.3 Cost estimates for such new programs  
24 as might be suggested or contemplated  
25 in the course of the Commission's  
26 investigations.

27 13. Areas for consideration under term of reference (h)

28 13.1 A study of voluntary and sponsored  
29 Canadian health care programs which now  
30 include drugs and pharmaceutical services as





benefits.

13.2 The suitability of expanding these programs, or some modification of them, as a general method of providing pharmaceutical services to the public.

14. Suggested study areas under term of reference (i)

14.1 Methods of financing new or extended programs for providing pharmaceutical services.

15. Problems for consideration under term of reference (j)

15.1 The nature and areas of pharmaceutical research presently being pursued in Canada and the institutions, organizations and individuals conducting it.

15.2 Deficiencies in present Canadian pharmaceutical research programs and recommendations for overcoming them.

16. Problems for study under term of reference (k)

16.1 Determination of the individual and family expenditures on drugs, and whether a high proportion of drug costs are borne by a relatively small proportion of the population, and, if so, why?

16.2 Possible definition of groups to whom the cost of drugs represent a significant financial problem.

16.3 If the previous studies in 16.1 and 16.2 shows that well defined groups incurring abnormally high drug costs do exist, suggestions for priorities within a drug assistance program which would







1 alleviate those cases of most urgent  
2 need.

3 16.4 Determination of stages in the  
4 development of comprehensive health care  
5 services programs in priority stages  
6 according to type or area of service  
7 and in keeping with conclusions  
8 established in the above studies (16.1 and  
9 16.2 and 16.3).

10 17. Suggested study areas under term of reference (1)

11 17.1 Health service programs in other  
12 countries which include drugs and  
13 pharmaceutical services among their  
14 benefits.

15 17.2 Experience of such programs in  
16 utilization of drugs and pharmaceutical  
17 services.

18 17.3 Proportion of total health care  
19 costs in such programs represented by  
20 drugs and pharmaceutical services.

21 Suggested Research Projects

22 18. The following research projects in the areas  
23 of pharmacy are recommended to the Commission.

24 a) Pharmacy manpower

25 b) Present and projected costs of drugs  
26 and pharmaceutical services in Canada.

27 c) Family and individual expenditure  
28 patterns for drugs and pharmaceutical  
29 services.

30 d) Historical experience of health care





1 programs in foreign countries.

2 19. Detailed outlines of these proposed studies  
3 which indicate their scope and nature are attached  
4 as appendices D, E and F.

5 20. The Canadian Pharmaceutical Association  
6 feels that the studies proposed above will provide  
7 information of sufficient importance to warrant the  
8 development of projects by the research staff of the  
9 Commission.

10 Outline of Future C.Ph.A. Submission

11 21. A tentative outline of the scope of the  
12 brief as presently being formulated for later submission  
13 to the Commission, is attached as Appendix G.

14 22. The Canadian Pharmaceutical Association is  
15 ready to expand this outline and the subsequent brief  
16 relative to additional questions which may arise during  
17 this preliminary hearing if it is within the capabilities  
18 and resources of the Association to do so.

19 23. The Association, likewise, is ready to expand  
20 its studies upon the request of the Royal Commission,  
21 itself, either now or at a later date provided that  
22 sufficient time is allowed in which to complete the  
23 assignment and provided, also, that such assignment  
24 is within the capabilities and resources of the  
25 Association.

26 Statement of Principles

27 24. The Canadian Pharmaceutical Association  
28 Statement of policy relative to health care plans  
29 is attached as Appendix H. This statement of policy  
30 has received unanimous approval of constituent pharmacy







1 organizations at their annual 1961 meetings and final  
2 approval at the 1961 Annual Meeting of this Association  
3 in August of this year at Hamilton, Ontario. It will  
4 be elaborated upon in the Association's main brief  
5 at a later date.

6 25. It is probable that the Commission will wish  
7 to obtain expert opinion on portions of submissions  
8 dealing with technical and professional aspects of  
9 pharmacy. It is respectfully submitted that only a  
10 pharmacist can provide such expert opinion. The eminent  
11 medical practitioners appointed to the Commission and  
12 the medical consultant engaged to assist the  
13 Commission unquestionably possess great knowledge of  
14 the clinical application of drugs. But it is  
15 respectfully proposed that, outside of the field of  
16 clinical application and therapeutic effectiveness  
17 of drugs, these able men possess no special competence  
18 in the professional and technical aspects of pharmacy  
19 and their opinions on these areas cannot be accepted  
20 as expert by this Association.

21 26. Because of the absence of a pharmacist on the  
22 Commission and the undoubted requirement for expert  
23 advice by the Commission on specialized areas of the  
24 practice of pharmacy, it is respectfully requested that  
25 a pharmacy consultant be appointed to assist the  
26 Commission.

27 (In this statement and its appendices where the  
28 initials, "C.Ph.A." are used, they refer to the  
29 Canadian Pharmaceutical Association.)  
30







Appendix A - to preliminary  
statement by Canadian Pharmaceutical  
Association

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Pharmacy Organizations in Canada

A.1 The association of the Royal Commission on Health Services with the profession of pharmacy has to date been chiefly through the office of the Canadian Pharmaceutical Association. Yet when public hearings are held in the various regions of Canada, provincial pharmaceutical associations and other organized pharmacy groups will undoubtedly be presenting submissions to the Commission. The purpose of this statement is to briefly describe the nature and purpose of the various pharmaceutical organizations and their relationship to the Canadian Pharmaceutical Association. More information, including the names of officers and addresses of these organizations will be made available if required by the Commission.

Provincial Statutory Pharmacy Organizations

A.2 As with other fields of health care, the control of pharmacy is vested in the provincial governments. All provinces have enacted legislation authorizing the establishment of provincial pharmaceutical organizations empowered to license those who may practice pharmacy in the province, set and collect fees, control and discipline their own members, and to regulate the conditions under which pharmacy may be practised including the dispensing and sale of drugs and medicines in the respective provinces. These organizations, established as associations, societies or colleges with the above





1 statutory obligations by provincial legislation, are  
2 referred to as statutory pharmacy organizations.

3 The Canadian Pharmaceutical Association

4 A.3 The Canadian Pharmaceutical Association is  
5 a federation of provincial statutory organizations.  
6 The objects stated on its Charter are: (a) To advance  
7 the science and practice of pharmacy; (b) to promote  
8 and protect the commercial interests of the members;  
9 (c) to promote the mutual interests of its  
10 associations, societies and colleges, and their members;  
11 and, (d) to bring together their members in professional,  
12 commercial and social gatherings.

13 A.4 All individual members of provincial statutory  
14 organizations are members of the Canadian Pharmaceutical  
15 Association. However, recently, the Quebec College  
16 of Pharmacists has given notice of withdrawing as  
17 a constituent-member of the Association. Because the  
18 constitution of the Association requires twelve months'  
19 notice of withdrawal, Quebec pharmacists are technically  
20 members until June 30, 1962. Notwithstanding this,  
21 the College of Pharmacists of the Province of Quebec  
22 considers itself not to be affiliated with the  
23 Canadian Pharmaceutical Association at the present  
24 time and may, therefore, not wish to be party to this  
25 submission.

26 A.5 The Canadian Pharmaceutical Association is  
27 governed by a Council composed of four representatives  
28 of each provincial statutory organization. In  
29 each case, two of these are appointed on the  
30 recommendation of the commercial pharmacy organization







1 in that province (see A.12). In addition, one  
2 representative from each of the following organizations  
3 is seated on Council:

4 The Canadian Conference of Pharmaceutical  
5 Faculties.

6 The Canadian Society of Hospital Pharmacists  
7 The Section of Industrial Pharmacists  
8 of the C.Ph.A.

9 A.6 The Canadian Pharmaceutical Association has  
10 no authority to impose its decisions on the various  
11 constituent statutory organizations who retain  
12 complete responsibility for the profession in their  
13 respective provinces.

14 The Canadian Conference of Pharmaceutical Faculties

15 A.7 The Conference is an organization of faculty  
16 members of the various schools, faculties and colleges  
17 of pharmacy, there being eight, in Canada. The  
18 purpose of this organization is to deal with all  
19 phases of pharmaceutical education in Canada.

20 Membership of the Conference consists of all faculty  
21 members who are pharmacists.

22 The Canadian Society of Hospital Pharmacists

23 A.8 The Society is a voluntary organization of  
24 Canadian hospital pharmacists with the object of  
25 improving the standards of practice of pharmacy in  
26 hospital. Branches of the Society, which are  
27 responsible to the national council, are organized in  
28 most provinces.

29 A.9 Membership in the Society is limited to  
30 those pharmacists who practise their profession in





1 hospitals.

2 Section of Industrial Pharmacists

3 A.10 The C.Ph.A. Section of Industrial Pharmacists  
4 is a voluntary national organization of pharmacists  
5 employed in the Canadian pharmaceutical industry.  
6 Membership is limited to individual pharmacists  
7 employed in industry who are members of the Canadian  
8 Pharmaceutical Association. The Section is the  
9 latest Canadian national pharmacy group to be organized  
10 and is in the process of writing suitable objectives  
11 and regulations. For the sake of clarity, it should be  
12 noted that the Section bears no relationship to the  
13 Canadian Pharmaceutical Manufacturers Association which  
14 has as its members certain companies engaged in the  
15 pharmaceutical industry.

16 Other National Pharmacy Organizations

17 A.11 In addition to the organizations represented  
18 on Council, which have just been described, several  
19 national pharmacy organizations of a highly  
20 specialized nature are closely associated with the  
21 Canadian Pharmaceutical Association.

22 a) The Conference of Pharmacy Registrars  
23 of Canada - an organization of the registrars of the  
24 various provincial statutory pharmacy organizations  
25 which meets annually to consider administrative  
26 problems of mutual interest.

27 b) The Canadian Foundation for the  
28 Advancement of Pharmacy - an organization of individual  
29 pharmacists and of corporate members with the object  
30







1 of providing financial support for Canadian  
2 pharmaceutical education and research. This is  
3 effected by means of grants to faculties and by  
4 scholarships, bursaries and loans to individual  
5 students.

6 c) The Canadian Academy of the History  
7 of Pharmacy - an organization of individual  
8 pharmacists, non-pharmacists and corporate members  
9 with the object of advancing interest in the history  
10 of pharmacy in Canada by encouraging research studies,  
11 the distribution of papers, the collection of items of  
12 historical interest and value, and such similar  
13 projects.

14 Other Provincial and District Pharmacy Organizations

15 A.12 In each province there are volunatry organizations  
16 of retail pharmacists which devote their attention to  
17 matters pertaining to the commercial aspects of the  
18 retail practice of pharmacy and common business  
19 interests.

20 A.13 In addition, district and local voluntary  
21 organizations of pharmacists may exist and may be  
22 affiliated either directly or indirectly with the  
23 provincial voluntary organizations.

24 A.14 Although these voluntary organizations are  
25 not directly affiliated with the Canadian Pharmaceutical  
26 Association, the individual members of such  
27 organizations are members of the Association by  
28 virtue of their registration with the provincial  
29 pharmacy organization.  
30







Appendix B - to preliminary statement  
by Canadian Pharmaceutical Association

Definitions of Pharmacy and Pharmacist

B.1 The following definitions of "pharmacy" and "pharmacist" are presented to the Commission to ensure a uniform interpretation of these terms as they are used in this statement, and in future submissions of the Canadian Pharmaceutical Association.

B.2 Pharmacy is that profession which is concerned with the art and science of preparing from natural and synthetic sources, suitable and convenient materials for distribution and use in the diagnosis, treatment and prevention of disease. It embraces a knowledge of the identification, selection, pharmacologic action, preservation, combination, analysis, and standardization of drugs and medicines. It also includes their proper and safe distribution and use whether dispensed on the prescription of a licensed physician, dentist, or veterinarian or, in those instances where it may legally be done, dispensed or otherwise made available to the consumer.

B.3 A pharmacist is one who, through academic qualifications and legal professional registration, is responsible for the preparation and distribution of the dosage forms of drugs. The pharmacist practices his profession through the compounding and dispensing of medical prescriptions, and through the comprehension and dissemination of information related to the science which embraces all knowledge of drugs, their identification, mechanism of action, toxicity, therapeutic activity, palatability, stability, dosage





1 form, potentiality with other drugs and synergism  
2 in combination, and includes the standardization  
3 and critical evaluation of medicinal agents and  
4 pharmaceutical preparations. The pharmacists's  
5 duties include general supervisory control combined with  
6 certain specific legal responsibilities relative  
7 to certain drugs, in addition to direct obligations  
8 concerning the purchase, storage and safeguarding,  
9 and distribution of drugs, in bulk chemical state  
10 or finished pharmaceutical form, whether such duties  
11 pertain to advisory, technical or administrative  
12 functions or to his occupation as a pharmacy  
13 practitioner.

14  
15  
16 Appendix C - to preliminary Statement  
by Canadian Pharmaceutical Association

17 An Elaboration on Areas and Problems Pertaining to  
18 Pharmacy Suggested for Study of the Royal Commission  
19 on Health Services.

20 Introduction

21 C.1 The purpose of this elaboration is to  
22 provide additional details to the Commission on some  
23 of the suggested areas and problems pertaining to  
24 pharmacy. Problems, outlined in the main body of the  
25 Statement, which appear to be self-explanatory, will  
26 not be included in this Appendix.

27 C.2 To many, the responsibility of pharmacy in the  
28 provision of total health care is confined to the  
29 filling of prescriptions. Those with a more intimate  
30 knowledge of pharmacy realize that it is considerably  
broader in scope and includes a wide variety of







1 professional activities.

2 Present Methods of Providing Drugs and Pharmaceutical  
3 Services

4 C.3 This area of study should include all  
5 operations concerned with the production and distribution  
6 of drugs. The following broad outline is suggested:

7 a) The manufacture of basic drugs and  
8 chemicals; the Canadian industry; foreign  
9 sources and supply.

10 b) The manufacture and sale of  
11 pharmaceutical preparations; the Canadian  
12 industry; foreign sources and supply.

13 c) The wholesale drug industry;  
14 warehousing and distribution.

15 d) Provision of drugs and pharmaceutical  
16 services through retail pharmacies.

17 e) Distribution of drugs and  
18 pharmaceutical services through  
19 hospital pharmacies.

20 Deficiencies in Present Method of Providing Drugs  
21 and Pharmaceutical Services

22 C.4 It is anticipated that existing deficiencies  
23 in the present methods of providing pharmaceutical  
24 services will be most apparent to the health  
25 professions closely associated with pharmacy and to  
26 the public who receive these services. These groups  
27 will undoubtedly make such deficiencies known to the  
28 Commission. It is also suggested that the Commission  
29 has a right to expect organized pharmacy to make  
30 a realistic analysis of its profession's own  
deficiencies and to report them.





C.5 Deficiencies may be of two types:

a) qualitative deficiencies - professional functions which are not being performed adequately and additional professional functions which might be assumed by pharmacy but which are not being accepted.

b) Quantitative deficiencies - lack of availability of drugs and pharmaceutical services to the general public and hospital patients. This deficiency may arise from a shortage of physical facilities and/or qualified personnel in some areas.

It may also arise from the inability of the patient to pay for the drugs and services required.

#### Improvements and Extensions of Existing Services

C.6 The need for improvements and extensions should follow logically a study of deficiencies as suggested in the previous section. Again, improvements may be quantitative or qualitative.

#### Methods of Effecting Improvements and Extensions of Services

C.7 In considering the implementation of suggested improvements and extensions of services it would be significant to determine whether these proposals could be effected through present methods of practice, by some modifications of present systems; or if such would require major changes in present patterns of practice. Most properly, pharmacy organizations will give consideration to ways and means of effecting such proposals and/or changes both with regard to proposals advanced by themselves and by other organizations and individuals.







1 Pharmacy Manpower -- Present Status and Anticipated  
2 Requirements

3 C.8 The answers to this question may only be  
4 obtained by conducting a study of the problem in all  
5 areas of pharmaceutical endeavour. A research project  
6 is outlined in Appendix D which will enable the  
7 Commission to assess this problem. The association  
8 considers this to be a most important research project  
9 beyond its resources, and in recommending it to the  
10 Commission gives its assurance of full co-operation and  
11 support.

12 The Development of a Ratio of Facilities to Population

13 C.9 Pharmaceutical services are provided to  
14 the general public through retail pharmacies which sell  
15 assorted items of commerce in addition to providing  
16 professional pharmaceutical services. This has lead  
17 to a general assumption that, from a professional  
18 service point of view, the majority of retail pharmacies  
19 are under utilized. A study of the requirement of retail  
20 pharmacies to provide professional services in the  
21 future should attempt to determine some significant  
22 ratio between the number of pharmacists and pharmacies  
23 and the general population.

24 Types of Drugs, Medicines and Therapeutic Devices  
25 Considered Essential

26 C.10 Before a study of the present cost of  
27 providing drugs is undertaken, there must be some  
28 agreement as to the types of drugs, medicines and  
29 therapeutic devices which are considered necessary  
30 for providing adequate health services. Cost studies  
may be confined to those drugs dispensed on prescription







1 or they may include the cost of commonly used  
2 household drugs such as acetylsalicylic acid, laxatives  
3 and other medication which is normally purchased  
4 without a prescription. The effect of this decision  
5 on the cost estimates is obvious.

6 C.11 It is suggested that only through exhaustive  
7 cost studies can accurate estimates be established  
8 relative to suggestions or proposals which may be  
9 forthcoming as a result of the Commission's  
10 deliberations.

11 C.12 The C.Ph.A. recommends that the Commission  
12 undertake a comprehensive study of costs relative  
13 to pharmaceutical services and provision of drugs  
14 through all existing sources as a vital research  
15 project required under term of reference (g) and  
16 as outlined in Appendix E. In this regard, the  
17 Commission is again assured of the full co-operation  
18 and consultation of the Association.

19  
20 Appendix D - to Preliminary Statement  
21 by Canadian Pharmaceutical Association

22 Manpower in Pharmacy

23 Introduction

24 D.1 Reasons for consideration of manpower.

25 (i) Efficient allocation of professional  
26 resources?

27 (ii) Changing role of the retail pharmacist  
28 may necessitate changes in training

29 (iii) Increasing need for manpower within  
30 some fields of pharmacy and a





1 decreasing need in other fields

2 could necessitate changes in

3 scope of university training.

4 (iv) What is optimum number of

5 pharmacists in each field of

6 pharmacy which would be necessary

7 for efficient flow of pharmaceutical

8 services to the public.

9 (v) Are present university resources

10 sufficient to supply future demands

11 for pharmacists.

12 D.2 Present Status of Pharmaceutical Manpower

13 (i) Census of present manpower

14 (a) Present employment

15 - retail

16 - hospital

17 (research

18 (

18 (administration

19 - manufacturing (

19 (production

20 (

20 (sales

21 (teaching

22 - university (faculty (

22 (research

23 (students

23 (administration

24 (

24 - government service (research

25 (

25 (armed forces

26 - retired

27 - outside of pharmacy

28 (b) Flow between fields of pharmacy

29 - employment history

30







- 1 (university  
2 (c) Training (Year of graduation  
3 (Degree  
4 (Province of Licensing  
5 (d) Licensing (Year  
6 (History of licensing  
7 (if more than one)  
8 (e) Personal (Age  
9 (Sex  
10 (Marital Status  
11 (Weekly hours worked  
12 (Weekly salary  
13 (ii) Concentration of present manpower.  
14 (a) Within each field of pharmacy (Province  
15 (b) Site of present practice (County  
16 and history (to find (Municipality  
17 migration pattern between (Outside  
18 provinces, areas, etc.) Canada  
19 (c) Relate (a) and (b) (hospital and  
20 retail only) to population areas,  
21 e.g., in cities, towns, urban  
22 areas of varying sizes (1961 Census  
23 data?)  
24 (d) Relate retail and hospital  
25 pharmacist concentration to  
26 concentration of physicians if  
27 similar survey conducted on  
28 medical profession.  
29 (e) Trends in concentration  
30 (e.g., trend to urban stores?)





D.3 Adequacy of Present Manpower Situation

- (i) Present need for pharmacists in each field (e.g., equilibrium position between supply and demand at present)
- (ii) Comparison of numbers actually engaged in each field and present requirements (e.g., how short are we of immediate requirements?)
- (iii) Estimation of wastage rates due to
  - (marriage of females
  - (retirement
  - (death
  - (failure at university
  - (failure to practice after university

D.4 Utilization of Professional Manpower

- (i) Professional capacity of a retail pharmacist
  - (a) How many prescriptions is he able to fill in a normal day?
  - (b) Estimate of time consumed in other professional activities.
- A. Dispensary management
  - ordering pharmaceuticals
  - keeping legal records (narcotics, etc.)
  - maintenance of dispensary equipment
  - management of professional personnel
  - supervising storage of drugs
- B. Professional responsibilities
  - consultation on general health





1 matters with customers

2 -- consultation on drugs and

3 prescriptions with medical

4 practitioners

5 -- keeping informed on new

6 pharmaceuticals and procedures.

7 Note: Possibly best to approach this on an overall  
8 proportionate basis -- e.g., Proportion of working  
9 hours spent on professional functions. Otherwise  
10 a detailed time and motion study would be necessary.

11 (ii) Present manpower requirements if  
12 professional capacities of pharmacists  
13 were fully utilized.

14 -- especially in urban areas.

15 D.5 Anticipated Future Requirements

16 (i) Population estimates

17 (ii) Estimates of proportion of pharmacists  
18 to population to maintain

19 (a) present level

20 (b) requirement level

21 (c) full utilization level

22 for each field of pharmacy

23 (iii) Estimation of wastage factors

24 D.6 Future Manpower Resources

25 (i) Projected university enrolment and  
26 capacity.

27 (ii) Projected pharmacy enrolment and capacity

28 -- consider changes in

29 (a) length of course

30 (b) curricula







(c) failure rate

(d) recruitment programs

D.7 Future Market for Pharmacists

-- relate future requirements and projected  
resources

-- estimate future equilibrium condition  
between supply and demand for pharmacists

-- estimate effects of general future trends  
e.g. (i) increasing proportion of women  
in pharmacy

(ii) changes in nature of various fields  
of pharmacy

(iii) increased opportunity for post-  
graduate studies

D.8 Comparisons with Other Countries

-- general trends only.

D.9 Conclusions

(i) Should professional manpower allocation  
between the fields of pharmacy be influenced?

If so, why should it be done, and how?

(ii) Should manpower resources in pharmacy  
(universities) be supported or not? How  
could this be accomplished?

e.g., (a) recruitment programs

(b) entrance requirements

(c) scope of university course

(d) protection policies of licensing  
bodies

(e) government grants





- (iii) Should changes be made in the scope  
of university training for pharmacists  
due to  
(a) changing role of the retail pharmacist?  
(b) changing proportions of opportunity  
between the fields of pharmacy?

NOTE: A study of this nature would require three  
independent surveys to supply the required  
information.

- (i) A survey of all registered pharmacists  
in Canada (at present, 8,940) for basic  
data  
(ii) A managerial opinion survey in all fields  
of pharmacy to provide data on professional  
utilization and anticipated requirements.  
(iii) A survey of all university facilities  
for the education of pharmacists for  
present enrolment, anticipated enrolment  
and graduates' lists from which can be  
drawn the number of pharmacists who are  
not registered. Also anticipated faculty  
requirements could be ascertained here.







Appendix E - to Preliminary Statement  
by Canadian Pharmaceutical Association

## Current and Projected Costs of Prescription Services to Canadians

E.1 Sources from which the People of Canada  
Receive Prescription Drugs:

- (a) Retail Pharmacists
- (b) Hospital Pharmacies (including  
                                (In patient government hospitals (  
  (Out Patient)
- (c) Dispensing doctors and dentists
- (d) Government Agencies which actually dispense  
and not just pay for prescription drugs.
  - (D.V.A.
  - (  
(i) Federal - (Armed forces                         etc  
                    (  
                    (Department of Health  
  
                    (Government Dispensaries  
                    (e.g. British Columbia)  
(ii) Provincial - (Welfare Department             etc  
                    (  
                    (Health Department  
  
                    (Welfare Department  
(iii) County - (  
                    (Health Department                         etc  
  
                    (Welfare Department  
                    (  
(iv) Municipal - (Health Department  
                    (  
                    (Institution for aged
- (e) Union or Industrial Dispensaries
- (f) Voluntary Health Agencies (e.g., Cancer clinics, Red Cross, Etc.)
- (g) Private Institutions
  - nursing homes and infirmaries
  - houses for aged

E.2 All areas must be assessed for costs (to public and/or payment agencies) and a method must be





1 established whereby these costs can be compared  
2 (e.g., all costs brought even with retail costs so that  
3 changes in proportionate distribution between sources  
4 can be evaluated).

5 E.3 In projecting costs, other factors must  
6 be considered, e.g.,

7 (1) Historical Trend

8 (2) Population Increases Expected

9 (3) Urbanization

10 (4) Manpower in medicine and pharmacy

11 (5) Utilization of drugs by age groups

12 and sex and the changing nature of these  
13 groups proportionately to total  
14 population. (i.e., more old people and  
15 fewer infant deaths)

16 (6) Anticipated changes in sales tax levels

17 (7) Inflationary trends in price index

18 (8) Increasing costs (to retailer) of new  
19 drugs

20 (9) Trends in costs of professional services

21 (10) Trends in number of doses contained in  
22 the average prescription.

23 E.4 In the advent of a comprehensive health care program,  
24 additional factors will bear on future costs.

25 (1) Increased utilization due to removal  
26 of economic barriers to both physician  
27 and pharmacist.

28 (2) Increased utilization due to increased  
29 access to pharmaceutical services (physical)  
30





(3) Disruption in proportions of dispensing  
done by various groups

(4) Disruption in pattern of prescribing  
(e.g., if prescriptions are free, more  
would be issued for drugs which do not  
require them)

E.5 The effects of possible components of such a  
plan would also require study.

- (1) effect of deterrent fees for service
- (2) effect of deductible clauses
- (3) effect of maximum benefit clauses
- (4) effect of selectivity of benefit drugs
- (5) effect of formulary system (i.e. generics)
- (6) effect of level and method of remuneration  
of those providing services under the plan.

It is realized that the consideration of  
cost in regard to possible components of a health plan  
should be secondary to consideration of the precepts  
of good health care, but the extent to which these  
elements could influence costs should be estimated  
anyway in order that they could properly be assessed.

E.6 A relationship between cost and availability  
of drugs and the length of hospital convalescence  
should be determined. This would have to be  
studied in relation to specific illnesses or abnormal  
states.







Appendix F

to Preliminary Statement by  
Canadian Pharmaceutical Asso-  
ciation

Family and Individual Expenditure and Utilization

Patterns for Drugs and Pharmaceutical Services.

Reasons for Studying Expenditure and Utilization Patterns  
for Drugs

F.1. To determine the degree to which such expen-  
ditures vary in relation to income level,  
family size, sex and age.

F.2. To determine if specific groups or catego-  
ries of individuals bear a major proportion  
of drug costs.

F.3. To determine if drug expenditures are a  
real barrier to adequate health care for  
some people -- and if so, to what proportion  
of all people and to what proportion of  
specific groups.

F.4. To determine if well defined groups exist  
that require assistance in obtaining neces-  
sary drugs.

F.5. To determine what types of drugs impose the  
greatest financial burden on groups that  
may require assistance or groups that show  
the greatest financial outlay in relation to  
income.

Information Required

F.6. Gross expenditures on prescribed drugs by  
type of drugs used per individual family per





- 1 specific time period.
- 2 F.7. Gross expenditures on non-prescribed drugs  
3 and medicines per individual family per  
4 specific time period.
- 5 F.8. Gross expenditures on prescribed drugs by  
6 type of drugs used per individual person  
7 per specific time period.
- 8 F.9. Gross expenditures on non-prescribed drugs  
9 and medicines per individual person per  
10 specific time period.
- 11 F.10. Data on income level and family size for  
12 each family studied.
- 13 F.11. Data on sex and age for each individual  
14 studied.
- 15 Analysis
- 16 F.12. Percentage distribution of families by  
17 gross expenditures according to family  
18 income level and family size.
- 19 F.13. Percentage distribution of individuals by  
20 gross expenditures according to sex and  
21 age.
- 22 F.14. Percentage distribution of individuals of  
23 specific sex and age classifications by  
24 gross expenditures according to types of  
25 drugs used.
- 26 F.15. Percentage distribution of families of  
27 specific income level and size classifica-  
28 tions by gross expenditures according to  
29 types of drugs used.
- 30







1 Method

2 F.16. This study would necessitate a consumer  
3 survey. It could well form part of a  
4 larger project covering utilization and  
5 expenditures on all forms of health  
6 services. Other considerations such as  
7 race or racial origin (e.g. - Eskimo,  
8 Indian, etc.) might also prove important  
9 in assessing needs of special groups or  
10 geographic areas.

11

12 Appendix G

13 to Preliminary Statement by  
14 Canadian Pharmaceutical Asso-  
15 ciation

16 Tentative Outline

17 Brief to the Royal Commission on Health Matters for later  
18 Submission by The Canadian Pharmaceutical Association

19 Introduction

20 G.1. Identification of Organization

21 G.2. Definition of Terminology

22 Background of Pharmacy

23 G.3. Organization of Canadian Pharmacy

24 G.4. Canadian Pharmaceutical Legislation - Its Object and  
25 Philosophy.

26 G.5. The Development of Canadian Pharmacy and Its Role in  
27 Modern Health Care.

28 G.6. The Provision and Distribution of Drugs and Pharma-  
29 ceutical Services in Canada.

30 G.7. The Estimated Cost of Pharmaceutical Services.





- 1 G.8. Present Methods of Providing Pharmaceutical Services  
2 for Indigents.
- 3 G.9. Estimated Manpower Requirements for Canadian Pharmacy.
- 4 G.10. Canadian Pharmaceutical Education and Research.  
5 Pharmacy in Comprehensive Health Care Programmes
- 6 G.11. A Statement of Policy of the Canadian Pharmaceutical  
7 Association Relative to Health Care Plans and an  
8 Elaboration of the Statement.
- 9 G.12. Methods of Providing Pharmaceutical Services in a  
10 Comprehensive Health Care Programme.
- 11 G.13. The Estimated Cost of Providing Pharmaceutical  
12 Services in a Comprehensive Health Care Programme.

13  
14 Appendix H

15 to Preliminary Statement by  
16 Canadian Pharmaceutical Asso-  
17 ciation

18 HEALTH MATTERS STUDY COMMITTEE

19 PROPOSED STATEMENT OF POLICY

20 RELATIVE TO HEALTH CARE PLANS.

21 1. The pharmacists of Canada are of the  
22 opinion that there are issues in the whole field of the  
23 provision of health care services which require clarifica-  
24 tion. We feel that health care programs should be  
25 examined in a light consistent with a sound philosophy  
26 which will assure a good standard of such care to every  
27 Canadian, yet which will also safeguard the rights of the  
28 individual and all minority segments of the population.

29 It is acknowledged that there appear to be  
30 certain deficiencies in prevailing systems of providing







1 health care. There are segments of the population for  
2 which adequate health care does represent a financial  
3 hardship. It is recognized, too, that there is a certain  
4 basic resistance in some quarters to the assumption of  
5 costs relative to illness, particularly in relation to  
6 drugs and therapeutic procedures. Neither of these is  
7 consistent with modern concepts of community social  
8 responsibility, nor with the availability of professional  
9 knowledge and ability.

10           2. During recent years the cost of modern  
11 health services has risen to a point where a significant  
12 number of Canadian families may be financially unable to  
13 meet the cost of a major or prolonged illness. In recog-  
14 nition of this, governments in Canada have already intro-  
15 duced a form of universal hospital insurance against a  
16 background of basic democratic principles.

17           The remaining elements of health care,  
18 including pharmaceutical services, may still present a  
19 financial problem to a portion of the population of  
20 Canada.

21           The profession of Pharmacy recognizes these  
22 existing deficiencies and is of the opinion that govern-  
23 ments can properly provide legislation to correct the  
24 situation. Pharmacy holds the opinion that such legis-  
25 lation should assure the practical availability of compre-  
26 hensive health care, including pharmaceutical benefits,  
27 to every Canadian. This profession believes that study  
28 should be made, initially, looking to the meeting of this  
29 objective through the expansion and extension of existing  
30 voluntary medical insurance and prepayment plans. These







1 plans would need to be expanded to provide pharmaceutical  
2 services and extended so as to include all who are  
3 presently ineligible to participate or who are financially  
4 unable to pay the necessary costs. Subsidization of the  
5 plans from public funds would make this possible.

6           Should research and study prove conclusively  
7 that it is not practical to provide an adequate standard  
8 of comprehensive health care by the expansion, extension  
9 and subsidization of existing plans, the profession of  
10 Pharmacy is prepared to accept in principle and co-operate  
11 in the establishment and operation of an alternative  
12 government sponsored comprehensive plan which would be  
13 consistent with all recognized precepts of good health  
14 care and which would make such care readily available to  
15 all people of Canada.

16           3. The C.Ph.A. considers any health care  
17 plan to be comprehensive only if it includes pharmaceutical  
18 services provided by pharmacists among its general health  
19 care benefits. Pharmaceutical benefits should be in the  
20 form of prescribed drug services and specified therapeutic  
21 devices and not in the form of reimbursement.

22           4. Pharmacy expresses the view that the  
23 idea of compulsion is basically distasteful but it is  
24 realized that the attainment of universal coverage is most  
25 desirable in the financing of any such health care pro-  
26 gram.

27           Compulsion does not respect the rights of a  
28 minority. The degree and nature of compulsion should not  
29 be such as to emasculate the initiative of the professions  
30 which could result in a possible lowering of standards of





1 health care, a possible impairment of professional educa-  
2 tion, a possible stifling of medical and pharmaceutical  
3 and related research, as well as a possible demoralization  
4 of individual practitioners within the professions.

5 Consequently, voluntary measures should be encouraged.

6           Moreover, the introduction of such a health  
7 care program should not stifle nor detract from efforts  
8 to provide the highest concepts of quality of health care  
9 in keeping with traditional professional responsibilities.  
10 Nothing, economic or otherwise, in such a universal scheme  
11 should be incompatible with such high standards or inter-  
12 fere with the relationship which presently exists between  
13 patient, physician, pharmacist and other members of the  
14 health professions.

15           Any such plan should be open and available  
16 to every citizen and should certainly provide for those  
17 who are financially unable to care for their own needs.  
18 Yet, it should safeguard the democratic rights of those  
19 who do not wish to receive its benefits.

20           5. Without limiting in any way the genera-  
21 lity of the foregoing statements, the C.Ph.A. states that  
22 to be acceptable to the pharmacists of Canada, any compre-  
23 hensive health care plan must observe the following funda-  
24 mental principles in respect to pharmaceutical benefits:

25           (1) Such plans shall recognize existing  
26 federal and provincial legislation concer-  
27 ning Pharmacy and/or drugs and nothing in  
28 these plans shall contravene such legisla-  
29 tion.

30           (ii) Drugs and all pharmaceutical services







1 shall be supplied directly to the public  
2 only by pharmacists through legally  
3 authorized and regulated retail pharmacies  
4 of the province concerned. In hospitals,  
5 the supplying of drugs and related profes-  
6 sional services shall be limited to bona  
7 fide hospital patients.

8 (iii) The profession of Pharmacy shall  
9 have direct representation on any body  
10 charged with the initiation and develop-  
11 ment of policies pertaining to pharmaceu-  
12 tical services. Pharmacists shall be  
13 directly involved in the administration  
14 of such policies.

15 (iv) The patient shall be free to obtain  
16 pharmaceutical services from the pharmacist  
17 of his choice.

18 (v) A pharmacist shall be free to conduct  
19 his practice, or any part thereof, outside  
20 of such health care plan if he so chooses.

21 (vi) Benefits shall include any and all  
22 drugs considered necessary by the physician  
23 for the welfare of the patient, as well as  
24 specified therapeutic devices. The only  
25 restrictions on prescribing should be in  
26 terms of quantity for any single prescrip-  
27 tion and the number of times it may be  
28 repeated.

29 (vii) While this Association does not look  
30 with favour upon the use of deterrents, the





1 fact must be faced that it has been neces-  
2 sary to introduce deterrents of a financial  
3 or otherwise restrictive nature, on pharma-  
4 ceutical benefits in every major health  
5 care plan on which data are readily available.  
6 Rather than introduce restrictions in  
7 undesirable stages, such deterrents as  
8 might seem advisable should be introduced  
9 at the beginning of a health care plan so  
10 that there may be a possible reduction of  
11 restrictions at a future time, and should  
12 be solely for the purpose of controlling  
13 over-utilization and NOT primarily as a  
14 source of revenue.

15 (viii) Members of the profession of Pharmacy  
16 shall have the right to determine the basis  
17 of their remuneration for professional  
18 services as distinct from payment for  
19 materials involved in the rendering of  
20 pharmaceutical services. The amount and  
21 manner of such remuneration shall be a  
22 matter of negotiation from time to time  
23 to reflect changes in economic conditions.

24 Mr. Commissioner and members, we are grate-  
25 ful for the opportunity of appearing at this preliminary  
26 hearing and submitting this statement to you. Thank you.

27 THE CHAIRMAN: Thank you, Dr. Summers.  
28 The recommendations contained in the last paragraph of  
29 your submission will have the consideration of the  
30 Commission at another hearing.





1 THE SECRETARY: The Canadian Labour Congress.

2 MR. ANDRAS: Mr. Chairman, members of the  
3 Commission, this statement was to have been read by our  
4 Vice-President, Mr. Knowles. Unfortunately he had to  
5 leave. I think the C.M.A. out-read him.

6 The Canadian Labour Congress appreciates  
7 this opportunity of appearing before you at this preli-  
8 minary hearing. The Congress will in due course and on  
9 the appropriate occasion submit a brief, setting out in  
10 some detail its views on the important issue of health  
11 care for Canadians.

12 The Congress considers the work of your  
13 Commission to be of the utmost importance. We look  
14 forward to two important results: (1) the assembly,  
15 analysis and publication of health data now not readily  
16 accessible; and (2) findings which will lead to improved  
17 health care for the Canadian people. With regard to the  
18 former, we are glad to note that you have obtained the  
19 services of an eminent social scientist and we hope that  
20 his research, while a by-product of your efforts, will  
21 add to our country's sum of knowledge on health matters.  
22 We hasten to add, however, the hope that the research  
23 findings will not be the main result of this Commission,  
24 as has unfortunately been the case on other occasions.

25 Your terms of reference are broad and appear  
26 to be comprehensive. They will form the basis for our  
27 submission to you, subject to such elaborations and  
28 modifications as may seem desirable to us and, we hope,  
29 helpful to you in your deliberations. At the same time,  
30 however, we should like to urge upon you the particular







1 importance of examining the following aspects of health  
2 services:

3 (1) unmet health needs among the Canadian  
4 people, their socio-economic implications  
5 and their relationship to existing methods  
6 of providing health services:

7 (2) those factors which together are  
8 likely to conduce to the provision of  
9 health care of a high quality, and, in  
10 this regard, the effective organization  
11 and co-ordination of health services,  
12 inclusive of personnel and facilities;

13 (3) the most equitable way of financing  
14 health care services, having regard to  
15 both the beneficiaries and the providers  
16 of services;

17 (4) the development and adaptation of  
18 adequate educational resources to meet  
19 the present and future health needs of  
20 the Canadian people; and

21 (5) the introduction of a comprehensive  
22 and universal health care program to  
23 replace existing methods of providing  
24 health services.

25 In our opinion, the foregoing, while not  
26 demanding your exclusive attention, are issues of such  
27 major proportions as to require more than ordinary review.  
28 The future well-being of this country may depend in large  
29 measure on the outcome of your inquiries and the conclu-  
30 sions you will reach.





1 THE CHAIRMAN: Thank you very much, Mr.

2 Andras.

3 THE SECRETARY: The Canadian Mental Health  
4 Association.

5 MR. DUBIENSKI: Mr. Chairman, my name is  
6 Dubiensi from Winnipeg. I am the National President of  
7 the Canadian Mental Health Association. I appreciate  
8 very greatly the opportunity of appearing before you today  
9 to give a summary and statement of the views which we have  
10 concerning the areas of problems to be covered by the  
11 Royal Commission.

12 I Representing the Association

13 Mr. Ian V. Dubiensi of Winnipeg, Manitoba,  
14 National President.

15 II What is the Canadian Mental Health Association?

16 The Association is a national voluntary  
17 society of more than 100,000 members, founded in 1918 and  
18 organized into 9 Provincial Divisions, in all provinces  
19 save Newfoundland, and more than 120 local branches.  
20 Each Provincial Division is governed by a volunteer Board  
21 of Directors, is advised by a professional planning  
22 committee and is represented on the National Board of  
23 Directors and the National Scientific Planning Council.  
24 The names of the members of these national governing and  
25 advisory bodies and the locations of national and provin-  
26 cial offices are attached herewith.

27 The objects of the Association are, briefly,  
28 to mobilize public support for an all-out attack against  
29 mental illness and to help provide scientific guidance in  
30 this attack. To these ends the program of the Association







1 is directed to four areas:-

- 2 1) Public information and education
- 3 2) Services to the mentally ill
- 4 3) Social action in fields of legislation
- 5 and planning
- 6 4) Promotion of scientific research

7 During 43 years of activity the Association,  
8 among its many accomplishments has:-

- 9 1) Conducted surveys of mental hospitals
- 10 and mental health services in all Canadian
- 11 provinces at the request of provincial
- 12 governments and furnished detailed reports
- 13 and recommendations, most of which have
- 14 been implemented by these governments,
- 15 2) initiated community mental health
- 16 clinics, assisted in the development of
- 17 psychiatric hospitals and other local
- 18 community mental health services,
- 19 3) introduced volunteer service programs
- 20 in mental hospitals in most provinces,
- 21 4) developed social rehabilitation
- 22 centres for ex mental patients in all
- 23 provinces,
- 24 5) organized continuing intensive programs
- 25 of public information and education about
- 26 mental illness and health,
- 27 6) developed a National Mental Health
- 28 Research Fund,
- 29 7) during the last 5 years has sponsored
- 30 an intensive study of Canada's mental





1 health services by an expert committee  
2 of psychiatrists assisted by consultants  
3 from other related scientific disciplines.  
4 (The report of this committee is presently  
5 being completed and will be available to  
6 the Royal Commission shortly).

7 III Areas and problems to be covered

8 The Association respectfully urges the  
9 Royal Commission to give careful attention to the  
10 following areas in the mental illness and mental health  
11 field:-

- 12 1) The tradition of stigma and discrimina-  
13 tion which has developed down through the  
14 years in connection with mental illness,  
15 mentally ill people and mental hospitals.
- 16 2) The present dimensions of mental ill-  
17 ness problems in terms of prevalence,  
18 hospital patients, direct and indirect  
19 costs.
- 20 3) Present patterns of treatment programs  
21 for mental illness in comparison with  
22 patterns of service for the physically ill.  
23 This should include consideration of
  - 24 (a) shortage of personnel
  - 25 (b) shortage of money
  - 26 (c) overcrowding of hospitals
  - 27 (d) isolated, state-controlled staff  
28 in large institutions
  - 29 (e) inadequacy of rehabilitation and  
30 research programs.





1 4) Difficulties and discrimination manifest  
2 in present financial arrangements covering  
3 treatment of mental illness, as illustrated  
4 by

5 (a) hospital insurance plans

6 (b) prepaid medical service plans

7 (c) research funds

8 5) New trends emerging in psychiatric  
9 treatment

10 (a) shift from custody to active  
11 treatment

12 (b) integration of psychiatric treat-  
13 ment with the rest of medical services

14 (c) regionalization of psychiatric  
15 facilities rather than isolated mono-  
16 lithic institutions

17 (d) development of out-patient and  
18 day-care community facilities

19 (e) decentralization of operations  
20 through the establishment of local  
21 mental health authorities

22 (f) the importance of continuity of  
23 care with the same professional  
24 personnel being available for out-  
25 patient, in-patient and after treat-  
26 ment care.

27 6) The urgent need for a rapid and exten-  
28 sive development of research in the mental  
29 illness and mental health field.

30 7) The need for a review and revision of







1 the legislation referrable to mental  
2 illness, the mentally ill and mental  
3 hospitals.

4 8) The possibilities for a preventive  
5 program in the field of mental health,  
6 and the relation to public health  
7 services, education of children, educa-  
8 tion of parents, etc.

9  
10 THE CANADIAN MENTAL HEALTH ASSOCIATION

11 National Scientific Planning Council

12 Chairman: Dr. R.O. Jones, Professor of Psychiatry,  
13 Dalhousie University, Halifax, N.S.

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30 Mrs. Helen Gemeroy, Assistant Professor of Nursing,





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- 10 Dr. E.E. Leyland, Clinical Instructor (Psychiatry),
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- 16 Dr. Burdett McNeel, Chief, Mental Health Division, Ontario
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- 24 Dr. C.A. Roberts, Medical Superintendent, Verdun Protes-
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- 27 versity, Toronto
- 28 Dr. Taylor Statten, Director, Dept. of Psychiatry,
- 29 Montreal Children's Hospital
- 30 Dr. A.B. Stokes, Professor of Psychiatry, University of







1 Toronto

2 Dr. J.S. Tyhurst, Professor of Psychiatry, University of  
3 British Columbia, Vancouver, B.C.

4

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1 At the appropriate time, Mr. Chairman,  
2 comment will be made on all of the above points on  
3 the national level and at the provincial division.

4 Mr. Chairman, would you please accept  
5 our assurance that this Association at all levels  
6 will be prepared to assist you in your deliberations,  
7 should you so call upon us.

8 THE CHAIRMAN: Thank you, Mr. Dubienski,  
9 and may you have a safe journey back to Winnipeg.

10 MR. DUBIENSKI: Thank you.

11 THE CHAIRMAN: Ladies and gentlemen, I think  
12 this is as far as we will go today. We will resume  
13 at 10:00 o'clock tomorrow morning hearing the  
14 submissions of those who have registered today, in  
15 the order in which registration was accomplished.  
16 Anyone here who may wish to make a statement, and  
17 has not registered, will have the opportunity to do  
18 so as we adjourn.

19 We are meeting at 10:00 o'clock, that is  
20 for the public hearing. The Commission itself  
21 will have a session at 9:00 o'clock in the morning but  
22 we will continue with the public hearing at 10:00.

23 ---Whereupon the Commission adjourned.

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*Mr McCutcheon*

# ROYAL COMMISSION ON HEALTH SERVICES

## PRELIMINARY MEETING

HELD AT

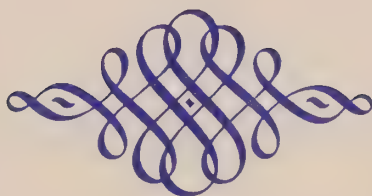
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15

## ERRATA

16

Volume 1 -

17

Page 27, line 19 delete "prophylactics"  
substitute "prophylaxis"

18

Page 27, line 24 delete "very"

19

20

Page 28, line 8 delete "debt cost"  
substitute "drug cost"

21

22

---O---

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the preliminary  
hearing held at Ottawa,  
Thursday, September 28th, 1961

---O---

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Prof. BERNARD BLISHEN

SECRETARY:

Maj. N. LAFRANCE

---O---





Ottawa, Ontario,  
Thursday,  
September 28th, 1961.

---On resuming at 10:00 a.m.

THE CHAIRMAN: Ladies and gentlemen, are we ready to come to order? We will proceed with the hearing of representations from amongst those who registered yesterday. Major Lafrance?

THE SECRETARY: Sudbury District Medical Society.

DR. M.J. LYNCH: Mr. Chairman and members of the Commission, I am Dr. M.J. Lynch of Sudbury. I am here primarily in the capacity of a private citizen and taxpayer, and secondly as Vice-President of my district medical society, which bids me bring you greetings.

As I have intimated to the Commission's Secretary, Major LaFrance, I intend to make a personal submission to the Commission. In this connection I wish to state here and now that this submission will in no way conflict with my parent professional bodies, that is the Ontario Medical Association or the Canadian Medical Association.

My submission arises from the fact that I have made a personal study of many foreign systems of medical care over a number of years, and I propose to present the lessons and the experience of some of these foreign schemes in the hope that we in Canada, by learning from history, will not have<sup>to</sup> relive it.

Firstly, I humbly beg leave to question the validity of a few statements which appear in the Royal







1 Commission's Chairman's statement circulated and read  
2 to us yesterday morning. Firstly, in the last  
3 paragraph on page 2 of the Royal Commission Chairman's  
4 statement of September 27th, 1961, there appears the  
5 following, and I quote:

6 "The view appears to be developing,  
7 taken into account increasingly by  
8 governments that opportunity for good  
9 health is a right possessed by all and  
10 should be available in one form or  
11 another to every citizen in Canada".

12 Indeed, I wish this were so. I am sure that  
13 each of us sincerely wishes there existed a neat  
14 formula for all our ills. The sentiment conveyed  
15 in the sentence which I have just quoted is a noble one,  
16 but on analysis, I find that it introduces a concept  
17 hitherto foreign to a democratic free society. By this  
18 I mean that the implication of the statement is that  
19 the citizen has the -- I might almost say -- the  
20 constitutional right to the services of certain other  
21 citizens by virtue of his claim to "opportunity for  
22 good health". Now food, clothing and shelter are  
23 fundamental to good health, but I may ask which  
24 society guarantees these essentials to all its  
25 citizens as an unqualified right of birth. But the  
26 concept goes deeper and further than this, since  
27 whenever we get talking about health and health care  
28 there appears to be an automatic transfer to  
29 superlatives. The best medical care must be available  
30 to all. The highest quality medical care. Now, this





1 is all very noble, but do we guarantee the best food,  
2 the best clothing, and the best shelter to all?  
3 Furthermore, since no one can deny the right of every  
4 citizen to gainful employment, I am forced to ask all  
5 governments how successful they have been in fulfilling  
6 this guaranteed right to work, and I do not exclude  
7 the U.S.S.R. in that, because they have a lot of  
8 seasonal unemployment. Again, as a Christian society,  
9 we do I believe subscribe to the notion that many, if  
10 not all, our rights are derived from God. In this  
11 context I may ask what of the congenital defect, the  
12 mongol, the mental defective. Where are their opportunities  
13 for good health? What about the man who injures himself  
14 by lack of exercise, by over-eating, by over-drinking,  
15 is he not, for whatever reason, repudiating his right?  
16 No one, and no society, regardless of how much money  
17 or effort it spends, can guarantee good health.

18 Secondly, there is an implication in the  
19 statement quoted that a number, apparently a significant  
20 number, of Canadians are now denied the opportunity  
21 of good health. If this is true, then the Commission,  
22 in my humble opinion is bound to ascertain the extent  
23 of this deficiency:

24 (1) Who, and how many, are without  
25 medical care?

26 (2) How many persons suffer illness  
27 that is financially catastrophic?

28 (3) Who, or how many, are denied  
29 essential or even adequate medical  
30 care because of inability to pay?







1 (4) Where, and how far, do Canada's  
2 standards of health care fall  
3 short of other advanced nations?

4 I refer you again to the statement of the  
5 Chairman's yesterday morning, on page 3, the first  
6 sentence includes amongst factors which go to make  
7 very high costs of illness the question of  
8 hospitalization. Now, I submit that the cost of  
9 hospitalization has already been dealt with.

10 On page 3 also in paragraph 3, we read,  
11 and I quote:

12 "People who do not work do not  
13 produce goods and services. The  
14 nation's output as a whole will be  
15 less than it would have been had  
16 proper health care either prevented  
17 or reduced the incidence of sickness."

18 In the next paragraph we read:

19 "Adequate health care means a  
20 higher standard of living."

21 These, sir, with all due respect are  
22 assumptions, the validity of which I wish to question,  
23 and I shall adduce evidence later to show that no-  
24 where have national systems of medical care increased  
25 national output, much less come to mean a higher  
26 standard of living.

27 Now, it seems to me that the Commission has  
28 an enormous task ahead - to ascertain facts and to  
29 sort these out from the emotional tangle surrounding  
30 them. It is my deep personal conviction that if the





1 Commission is to do a real and thorough job upon  
2 which decisions for the future can be made, the effect  
3 of which will not be deleterious to the nation's growth,  
4 economic and political well-being in ten, twenty or  
5 one hundred years from now, it must of necessity cast  
6 its net even wider and deeper than indicated.

7           Someone, I believe, has already referred to  
8 the Beveridge Report. I wish to remind this hearing  
9 that since the writing of his report Lord Beveridge  
10 has frankly admitted that many of the assumptions  
11 upon which his conclusions and report were based  
12 were in fact fallacious. At this very time, Professor  
13 Jukes of Oxford (Econ), is engaged in a study, the  
14 first reports of which show that the British Medical  
15 Health Scheme was not only a mistake but that it was  
16 unnecessary. I am confident that no one here wishes  
17 a similar train of events in Canada. I would, therefore,  
18 humbly submit that the Royal Commission should inquire  
19 into the following

- 20           (1) How much responsibility may safely  
21               be removed from the people, consistent  
22               with the maintenance of democratic  
23               freedom?

24           This may sound as a cliché, and I will not  
25 go into it now, because it is very involved and long,  
26 but I shall do in my later submissions.

- 27           (2) How much inflationary pressure  
28               can Canada's economy stand, and yet  
29               maintain a competitive position in  
30               world markets?





1 Now, very briefly, I shall not go into this  
2 at great length, I just wish to show certain of the  
3 fallacies that are conveyed. I would remind this  
4 hearing that Sweden's National Health Scheme, in  
5 other words, socialized medical care, as far as  
6 physicians' services, was not introduced until January  
7 1st, 1955. From 1950 until 1957 the national  
8 product of Sweden increased roughly, and these  
9 figures are from memory, but are substantially correct,  
10 from 24 to 42 billion kroner. The kroner is 19 cents.  
11 Superficially, this looks very impressive. However,  
12 it ignores other considerations which are very well  
13 worth going into.

14 If you examine the consumer price index at  
15 the same time, you will find that in Sweden it goes  
16 from 101 points in 1950 to 145 points in 1957, and  
17 a little calculation will show you that the inflationary/<sup>pressure</sup>  
18 has increased. The point is that Sweden could carry  
19 this, because the citizens had a very low rate of pay,  
20 but could Canada carry a similar thing? This, I  
21 think, is what the Commission has to inquire into,  
22 and furthermore this is not just a simple thing,  
23 because as the costs go up there is an automatic  
24 demand and need for more social security benefits.  
25 In reality, the poor become more poor still.

26 (3) I believe personally that the  
27 Commission must inquire where  
28 any national health schemes  
29 have improved the actual health of  
30 the people, and where these schemes







1 can be shown to have caused an  
2 increase in national output.

3 (4) I submit the Commission must  
4 inquire into what have been the  
5 effects on the professional standards  
6 morbidity, mortality statistics,  
7 recruitment of the right type  
8 of student to medicine, and on  
9 research in those countries  
10 with a national health scheme.

11 (5) I want to submit that the  
12 Commission must inquire into  
13 the effects of overall security  
14 schemes upon the national  
15 psychological characteristics  
16 of the peoples of the countries  
17 in question.

18 You have recently seen produced by our own  
19 CBC a feature called: Trouble in Paradise, in Sweden,  
20 and there is very substantial trouble, and if you have  
21 gone into the statistics you will find that Canada has  
22 the lowest rate of juvenile delinquency in advanced  
23 western countries.

24 In closing this morning, I would like to  
25 say by all means let us help those who cannot help  
26 themselves, and ease the burden of costly illness, but  
27 let us not try to build a national bed for everyone  
28 lie on.

29 Social security to a nation is like a  
30 pension to an individual. It is associated with





1 decline not with vigour. The nation that has all its  
2 wants satisfied, all its needs fulfilled, fades  
3 imperceptibly from the stage of world affairs.

4 THE CHAIRMAN: Thank you, Dr. Lynch. You will  
5 not expect any comment from me, except to say that  
6 it is gratifying to know that at least one member  
7 did listen to me yesterday morning, and knows exactly  
8 what I said.

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1 THE SECRETARY: The Canadian Chiropractors'  
2 Association.

3 MR. BURTON: Mr. Chairman and members of  
4 the Commission, my name is John S. Burton. I am the  
5 General Counsel for the Canadian Chiropractor's Association  
6 and counsel also for the British Columbia Chiropractors'  
7 Association. I come as far from home as anyone attending  
8 this Commission. I think I was here first but also it  
9 looks as though I will be home last.

10 I came here with one thought in my mind and  
11 that was in response to the invitation which you sent to  
12 everyone that at this present hearing we should present,  
13 in a general way, the principles and areas which we think  
14 should be covered in relation to our own particular field.

15 Yesterday I was regaled by some briefs which  
16 it seemed to me did not quite follow that pattern so that  
17 if you will excuse me, I shall make one or two extempora-  
18 neous remarks prior to the very slight and short statement  
19 which I had previously prepared.

20 At the outset perhaps I should warn you that  
21 the brevity of my remarks as compared to the loquacious  
22 remarks of the medical practitioners yesterday should not  
23 be interpreted as being in any sort of ratio of the limit  
24 of importance of the profession. I was struck by one  
25 remark of my learned friends, to this effect: that this  
26 Commission should not take into consideration quacks,  
27 cults and pseudo-scientific methods. I think I am more or  
28 less correct in what I say and in that, of course, I  
29 heartily agree.

30 I am here not representing any such body





1 but the Chiropractors' Association across Canada which admini-  
2 sters to the health needs of a large segment of the popu-  
3 lation of Canada and when I say that, I would amplify it  
4 by informing the Commission that there are upwards of  
5 1,200 practitioners in Canada and most with legislative  
6 sanction.

7                   The Canadian Chiropractors' Association is a  
8 body incorporated under the Letters Patent of Canada and  
9 each province having legislation is governed by their own  
10 Chiropractors' Act which has been in force for many, many  
11 years.

12                   As a very, perhaps brief indication of the  
13 popular acceptance of chiropractors, I should like to  
14 advise the Commission that after the Second War the D.V.A.  
15 sponsored chiropractic training in the Canadian Memorial  
16 Chiropractic College which was the first college to be  
17 set up in Canada and estimates are that some one-half a  
18 million to three-quarters of a million dollars was spent  
19 by the Government of Canada in the education of chiroprac-  
20 tors.

21                   The Workmen's Compensation Boards in most  
22 provinces of Canada recognize chiropractics on an equal  
23 basis with medicine. In other words, an injured workman  
24 in the Province of British Columbia particularly, and I  
25 understand the same situation is elsewhere, may decide  
26 as to what type of practitioner he shall go and he has  
27 the right to choose a chiropractor without any medical  
28 reference at all, and those services are paid for under  
29 the Workmen's Compensation Act.

30                   It is not my intention to go further into



JOHN S. BURTON  
Barrister and Solicitor  
Notary Public

*Mr Mc Cutcherson*  
*filed*  
*on record*  
404 Randall Building  
535 Georgia Street West,  
Vancouver 2, B.C.

October 24th, 1961

Mr. N. Lafrance,  
Secretary,  
Royal Commission on Health Services,  
Daly Building, P.O. Box 1173,  
Ottawa, Ontario.

Re: Canadian Chiropractic Association

Dear Sir,

On September 28th, 1961. on behalf of the Canadian Chiropractic Association, I made a preliminary statement to the Commission. Erroneously, I read what I thought to be a quotation from a brief presented the previous day, by the Medical Association.

My error appears in the official transcript of the proceedings, page 192, commencing at line 16, reading as follows:

"Yesterday, the Canadian Medical Association's brief had this to say and I quote it as nearly accurately as I can, 'Our desire' said the brief, 'is to see that the people of Canada should receive the best and most comprehensive care. It is not essential nor desirable that any one segment of the population of the serving organizations which make up the entire field of socio-medical services should cause to be eliminated from that comprehensive care any other service or any form of care under any circumstances so that any individual portion of the population should be denied the services which could be made available to them'. In my humble submission, that is a very essential and worthwhile contribution which the Canadian Medical Association made because ---" (ending in the middle of line 29).

Confirming my previous correspondence with you, I should like the transcript corrected, to delete reference to the quotation as emanating from the brief of the Canadian Medical Association and in its place, to insert the following;

"It is the desire of the Canadian Chiropractic Association to see that the people of Canada receive the best and most comprehensive care. It is not essential nor desirable that any one segment of the population of the serving organizations which make up the entire field of socio-medical services should cause to be eliminated from that comprehensive care any other service or any form of care under any circumstances so that any individual portion of the population should be denied the services which could be made available to them".

The transcript will then continue after the word "because" in line 29.

I very much appreciate your assistance to me in respect to this correction and regret the incident.

Yours sincerely,

(sgd) JOHN S. BURTON

JSB/ekp







1 this field at this time because briefs will be presented  
2 both by the Canadian Chiropractors' Association itself,  
3 and I think in most provinces in Canada and in that brief  
4 we will more particularize what I am saying here and also  
5 point out the educational requirements of chiropractors  
6 and a brief will be presented by the Canadian Memorial  
7 Chiropractic College in Toronto along with our main brief.

8           The educational qualifications, very briefly,  
9 are: the chiropractor must have, in the Province of  
10 Ontario, for instance, senior matriculation and then a  
11 course of four years in the Chiropractic College which  
12 teaches basic science subjects as well as those belonging  
13 particularly to chiropractics.

14           I have one more observation to make which  
15 I think seems to me, in any event, to be of importance.  
16 Yesterday the Canadian Medical Association's brief had  
17 this to say, and I quote it as nearly accurately as I  
18 can: "Our desire" said the brief, "is to see that the  
19 people of Canada should receive the best and most compre-  
20 hensive care. It is not essential nor desirable that any  
21 one segment of the population of the serving organizations  
22 which make up the entire field of socio-medical services  
23 should cause to be eliminated from that comprehensive care  
24 any other service or any form of care under any circum-  
25 stances so that any individual portion of the population  
26 should be denied the services which could be made avai-  
27 lable to them". In my humble submission that is a very  
28 essential and worthwhile contribution which the Canadian  
29 Medical Association made because, as we will I think  
30 amply demonstrate to this body the Chiropractors'





1 Association belongs to one of those groups which the  
2 public of Canada can use and it does constitute an impor-  
3 tant aspect of the health care of Canada to which of  
4 course this body is consecrated.

5           One other remark which I should like also  
6 to make is this: that during the last number of years,  
7 particularly, there has been a very vast acceptance of  
8 the theories of chiropractics. For 66 years the chiro-  
9 practors have studied the effects of disturbed spinal  
10 balance on other systems of the body and for some period  
11 of time these theories were not in great acceptance by  
12 other health bodies, but I was reminded yesterday in an  
13 issue of the Canadian Medical Journal of some two or three  
14 or four years ago, this statement was made in the journal  
15 in relation to chiropractics: "If you can't whip them,  
16 join them at least to the extent of borrowing their tech-  
17 niques", and that, I submit, Mr. Chairman, members of the  
18 Commission, illustrates the profound acceptance now of  
19 chiropractics not only in the public mind but also in the  
20 health field by other professional bodies.

21           Now, Mr. Chairman, I come to the part of my  
22 presentation which I came originally to present and that  
23 is to outline the general field which we think this Commis-  
24 sion should look into in the study particularly related to  
25 chiropractics.

26           I am not suggesting, of course, that there  
27 will be other briefs presented by other organizations  
28 which will have too much bearing, perhaps, on our field  
29 but in broad outlines we suggest that this Commission  
30 should spend its efforts in implementing, or finding







1 means of implementing a better care by chiropractics to  
2 all the citizens of Canada. That is a very general state-  
3 ment. As we say in law, without limiting the generality  
4 of that statement I would specifically suggest one or two  
5 headings: first, we should like consideration be given to  
6 the methods of improving chiropractic education, including  
7 government grants to chiropractic educational institutions  
8 and to students themselves.

9               Secondly, government grants for chiropractic  
10 research. Third, use of tax-supported institutions such  
11 as diagnostic laboratories, hospitals, including mental  
12 and rehabilitation centres available to doctors of chiro-  
13 practices.

14               Fourth, the chiropractic care for military  
15 personnel and veterans. Now this I understand has been  
16 supported and requested by the Canadian Legion now for  
17 several years.

18               Fifth, chiropractic care for old-age pensio-  
19 ners, indigents and welfare cases.

20               Sixth, chiropractic examinations as a preven-  
21 tive measure in schools, public clinics, industry, etc.

22               And lastly, seventh, ways and means of  
23 gaining and improving chiropractic legislation where neces-  
24 sary.

25               I quite appreciate Mr. Chairman, members of  
26 the Commission, that a large part of what I have said  
27 here pertains particularly to Provincial matters, but  
28 nevertheless as we heard yesterday it was very hard to  
29 segregate what might be termed strictly provincial and  
30 what pertains to Canada as a whole.





1 I am sure that we will be very pleased to  
2 present not one but several briefs before the ending of  
3 this Commission. Thank you.

4 THE CHAIRMAN: Thank you very much Mr.  
5 Burton. I can appreciate the fact that you feel an extra  
6 day away from Vancouver is a great loss, the more so when  
7 we appreciate what the lack of manpower is doing to the  
8 B.C. lines.

9 THE SECRETARY: L'Association des Hôpitaux  
10 Catholiques du Canada et L'Association des Infirmières  
11 Catholiques du Canada.

12 REV. PÈRE LORENZO DANIS, O.M.I.: Monsieur  
13 le président, messieurs les membres de la Commission et  
14 Mademoiselle Girard, je représente ice ce matin d'abord  
15 l'Association des hôpitaux catholiques du Canada et aussi  
16 l'Association des infirmières catholiques du Canada.

17 La secrétaire, Mlle. Turcotte, devait être  
18 ici hier pour représenter l'Association des infirmières  
19 catholiques, mais elle n'a pu venir. Cependant, je dois  
20 dire que l'Association des infirmières catholiques présen-  
21 tera un mémoire à la Commission.

22 Je tiens d'abord à parler en français parce  
23 que l'Association principale que je représente ce matin  
24 est une association composée en grande partie d'hôpitaux  
25 de langue française. Nous avons sept conférences d'hôpi-  
26 taux catholiques au Canada, une pour chacune des provinces  
27 de l'Ouest, une pour la province d'Ontario et, depuis  
28 quelque temps, une pour la province de Québec, et les  
29 quatre provinces maritimes ont aussi leur conférence.

30 Nous sommes heureux d'avoir l'occasion de





1 présenter les vues de nos hôpitaux catholiques devant les  
2 membres de la Commission. Nous reconnaissons bien l'import-  
3 tance d'avoir une voix unie pour représenter tous les  
4 hôpitaux du Canada, pour présenter leurs points de vue,  
5 et nous espérons que l'Association des hôpitaux du Canada,  
6 ainsi que toutes les associations qui en font partie,  
7 pourront, par l'intermédiaire de leur association nationale,  
8 faire valoir leurs points de vue.

9 Nous souhaitons que tous les hôpitaux catho-  
10 liques pourront accepter les points de vue et la présenta-  
11 tion de points de vue par l'Association des hôpitaux du  
12 Canada.

13 Cependant, nous croyons que nous devrions  
14 ajouter un chapitre au mémoire qui sera présenté par  
15 l'Association des hôpitaux du Canada.

16 Ce matin, je voudrais signaler un problème  
17 qui me semble être angoissant, un des problèmes les plus  
18 importants que votre Commission aura à étudier, soit celui  
19 du sort de nos hôpitaux catholiques, des hôpitaux organisés  
20 et dirigés par des communautés religieuses. La situation  
21 dans la province de Québec est peut-être moins embarras-  
22 sante pour le moment, parce que c'est seulement depuis  
23 quelques mois que l'on y a établi l'assurance - hospitali-  
24 sation, mais la situation est vraiment critique dans cer-  
25 taines provinces.

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1 Mr. Chairman, members of the Commission,  
2 the Catholic Hospital Association of Canada welcomes  
3 this opportunity to present its views to this  
4 Commission.

5 As I have said in French, we do hope the  
6 Canadian Hospital Association will be able to speak  
7 in the names of all the hospitals of Canada, of  
8 all the provincial organizations and of all our  
9 conferences which are members of the Canadian Hospital  
10 Association.

11 The Catholic Hospital Association, of which  
12 I am the Executive Director, has seven conferences  
13 of catholic hospitals and it has three hundred  
14 hospitals as members of its association. Because of  
15 the peculiar situation of some of our hospitals, it  
16 would be expected that a chapter will be added to  
17 the brief of the Canadian Hospital Association when  
18 this brief is presented to the Commission here. We  
19 do feel, however, that there is an urgent problem,  
20 and we do hope that the members of the Commission  
21 will be able to study this problem as they begin their  
22 work on the Commission.

23 Our hospitals in many certain regions of the  
24 country are in very difficult financial circumstances.  
25 One of our hospitals has had to turn everything over  
26 to the government, one of our communities; another  
27 hospital is about to close its doors, and this is  
28 as a result of the national legislation which does not  
29 share the costs of depreciation, of interest on  
30 capital with the provinces and reimbursing the hospitals





1 for the care of the sick. Some of the provincial  
2 governments have provided the hospitals with the  
3 cost of interest on capital and depreciation on buildings,  
4 but others have not done so. We submit that this  
5 is a crucial problem, and we do hope that the  
6 Commission will give very serious consideration to the  
7 financial plight of our hospitals and that they will  
8 seek to solve this difficult problem.

9 THE CHAIRMAN: Thank you very much, Father  
10 Danis.

11 THE SECRETARY: The Canadian Council on  
12 Hospital Accreditation.

13 MR. ROBINSON: Mr. Chairman, members of the  
14 Royal Commission on Health Services, my name is  
15 Robinson, Emerson Robinson, from Winnipeg, and I am  
16 Chairman of the Canadian Council on Hospital  
17 Accreditation. With me today is Dr. W.I. Taylor,  
18 Executive Director, who also represents the Canadian  
19 Council.

20 The Canadian Council is a voluntary body  
21 made up of representatives from the four following  
22 bodies:

23 L'Association des Medecins de Langue  
24 Francaise du Canada

25 The Royal College of Physicians and Surgeons

26 The Canadian Medical Association

27 The Canadian Hospitals Association

28 The purposes and objectives of the Canadian  
29 Council are as follows:

30 First, to conduct a survey and educational







1 program for Canadian hospitals which will encourage  
2 Canadian physicians and hospitals voluntarily to  
3 apply certain basic principles of organization and  
4 administration for the efficient care of the patient.

5 Secondly, to promote a high quality of  
6 medical care in all its aspects.

7 Thirdly, to maintain essential diagnostic  
8 and therapeutic services in hospitals through the  
9 coordinated efforts of organized medical staff and  
10 the governing boards of hospitals. Also to establish  
11 standards for hospital operation and to assist  
12 hospitals in attaining these standards. Again to  
13 recognize compliance with standards by the issuance  
14 of certificates of accreditation.

15 Fourthly, to assist and cooperate with the  
16 Canadian organizations having programs of approval  
17 for hospital internship and for advanced medical  
18 training.

19 Fifthly, to assume such other responsibilities  
20 and conduct such other activities which are comparable  
21 with the operation of the hospital accreditation  
22 program.

23 We believe, sir, that the Canadian Council  
24 must remain a voluntary association if it is to fulfill  
25 its purposes successfully. We also believe that  
26 because health is a provincial responsibility, being  
27 under the B.N.A. Act, the maintenance of hospital  
28 care between provinces is by means of an organization  
29 such as the Canadian Council. One of our chief  
30 problems is to assure the accreditation program's





1 continuing independence, its national and bilingual  
2 character and its voluntary support, and our brief  
3 will discuss this and certain other problems which  
4 confront us in developing and extending the  
5 accreditation program, together with specific  
6 recommendations for the consideration of this Royal  
7 Commission. Thank you, sir.

8 THE CHAIRMAN: Thank you, Dr. Robinson.

9 THE SECRETARY: The Canadian Chamber of  
10 Commerce.

11 MR. McNALLY: Mr. Chairman and Commissioners,  
12 I was accompanied yesterday by Mr. F.J. Cunningham,  
13 who is the chairman of our health services committee,  
14 who unfortunately had to return today to Montreal. I  
15 am W.J. McNally, manager of the policy department  
16 of the Canadian Chamber of Commerce.

17 I would like first to say, Mr. Chairman and  
18 members of the Commission, that the Chamber would like  
19 to record its appreciation of the open-minded way in  
20 which these hearings are being conducted, and we note  
21 right from the onset of the hearings the very full way  
22 in which you are canvassing opinion, and we also note  
23 that this hearing, which provides an exchange of  
24 opinion, is symptomatic of that open-mindedness and will  
25 produce in our opinion the best possible medical care  
26 for Canadians and, with that, of course, we are in  
27 complete accord.

28 We have told the Commission, Mr. Chairman,  
29 that we will be presenting a brief later on, and the  
30 only thing I would like to say this morning is to make







1 some brief observations related to the notice that  
2 was sent out with respect to this preliminary hearing  
3 and the notice which indicated that statements of  
4 principles which various groups may feel should guide  
5 the Commission in proceeding with its inquiry are  
6 invited. I would like to make a brief observation on  
7 that sentence and also to suggest as a conclusion of  
8 my remarks certain studies which may be made available.

9 At the outset, Mr. Chairman, and members  
10 of the Commission, I should like to make it perfectly  
11 clear that the Chamber believes that the attainment  
12 and preservation of national health should be a  
13 primary objective for the Canadian people. It also  
14 believes that the individual himself is primarily  
15 responsible for the attainment of this objective.

16 The Chamber respectfully suggests that the  
17 Commission, in considering questions of national  
18 health, should relate them to the many other welfare  
19 benefits now available to the Canadian people. The  
20 Chamber is concerned about further advances into the  
21 welfare state. At the present moment approximately 45  
22 per cent of all the taxes collected at the federal  
23 level are required to meet current welfare payments.  
24 These obligations of the country are irrevocable and  
25 are increasing rapidly. The Chamber suggests that  
26 any further obligations of a welfare nature should  
27 be considered with great caution to avoid the risk  
28 of the burden of payments becoming unbearable in the  
29 national economy.

30 The Chamber also suggests that the freedom







1 of the individual and freedom of enterprise should  
2 receive constant consideration by the Commission.  
3 A vast proportion of the Canadian people has demonstrated  
4 its ability to meet the costs of poor health. It is  
5 suggested that when costs are beyond the ability of  
6 the individual to pay, this is the area which  
7 constitutes probably the most important field for  
8 examination. In this same connection it is suggested  
9 that the Commission should give most serious  
10 consideration to some of the unfortunate results that  
11 would inevitably flow from any system of nationalized or  
12 socialized medicine; it would be unavoidable that  
13 government control of the healing professions and  
14 their allied services would increase rapidly, with  
15 consequent regimentation and serious interference with  
16 the freedom of the people.

17 We believe that as this enquiry commences  
18 it is pertinent to quote a paragraph from a Senate  
19 Finance Committee report made in June, 1955. The  
20 paragraph stated:

21 "Above all it is important to keep  
22 alive in the minds of all the people of  
23 the nation an understanding of what  
24 freedom means. People may clamour for  
25 security - many are doing that today -  
26 but it should never be forgotten that  
27 if personal freedom is sacrificed for  
28 personal security provided by governments,  
29 the individual can have no guarantee that  
30 in the end he will have either freedom





1 or security."

2 Finally, the Canadian Chamber of Commerce  
3 wishes to suggest that statistics and other  
4 pertinent information which the Commission's research  
5 staff will produce and which is available from other  
6 sources such as D.B.S. and the Department of National  
7 Health and Welfare, should be made available to  
8 interested parties at as early a date as possible,  
9 perhaps in the form of a white paper. That is the  
10 submission.

11 THE CHAIRMAN: Thank you very much, Mr. McNally.  
12 That last suggestion that you made is one that some  
13 consideration has been given to, but we have not yet  
14 been able to formulate the mechanics of it.

15 MR. McNALLY: Quite so.

16 THE SECRETARY: The Canadian Nurses' Association.

17 MISS CARPENTER: Mr. Chairman, my name is  
18 Helen Carpenter.

19 As President of the Canadian Nurses'  
20 Association I represent over 60,000 graduate registered  
21 nurses across Canada. The Canadian Nurses' Association  
22 is a federation of ten provincial registered nurses'  
23 associations. It was founded 53 years ago (in 1908) and  
24 incorporated in 1925.

25 Mr. Chairman, the Canadian Nurses' Association  
26 is keenly interested in the work of the Royal Commission  
27 on Health Services. The terms of reference are broad  
28 and will provide opportunity for enumeration of several  
29 areas of concern to the nursing profession, for example.  
30







- i. The quality of nursing care;
- ii. The co-ordination of nursing with other health services;
- iii. The effective utilization of nursing personnel;
- iv. The recruitment of well qualified students to schools of nursing;
- v. The quality of educational programs;
- vi. The need for more well qualified nurses in teaching, administration and research in both nursing service and nursing education.

These are complex problems that the Canadian Nurses' Association has long recognized cannot be solved by the nursing profession alone. With this in mind, the Association called a National Conference on nursing three years ago to which representatives of several professional groups and the public were invited. The purpose of this Conference was to bring to the attention of related professions and citizens matters of concern to nurses.

In addition to holding this National Conference, the Canadian Nurses' Association has undertaken, or cooperated in, a series of studies in the fields of nursing service and nursing education. Among the more recent of these are:

1. A study of the function and activities of head nurses in a general hospital.
2. A study of basic nursing education in a demonstration school.





1                   3. An evaluation of 25 hospital schools  
2                   of nursing in Canada.

3                   These reports, of course, have been published  
4 and are available.

5                   Arising out of the recommendations of the  
6 latter study, the Canadian Nurses' Association is  
7 presently committed to three major projects:

8                   1. A study of the whole field of nursing  
9                   education in Canada;

10                  2. A school improvement program designed  
11                  to assist schools of nursing in  
12                  improving their educational programs.

13                  3. A study to establish criteria for the  
14                  evaluation of the quality of nursing  
15                  service in clinical areas.

16                  Progress reports of these studies will be  
17 given to the Commission as they become available.

18                  The Canadian Nurses' Association will be  
19 submitting a brief in which the areas of concern  
20 mentioned above will be explored in some detail. In  
21 addition, the provincial registered nurses' associations  
22 will undoubtedly be making submissions.

23                  Mr. Chairman, may I assure you of the fullest  
24 cooperation of the Canadian Nurses' Association in the  
25 work of the Commission. Thank you.

26                  THE CHAIRMAN: Thank you very much, Miss  
27 Carpenter.

28                  THE SECRETARY: The Canadian Tuberculosis  
29 Association and the Canadian Thoracic Society.

30                  DR. G.J. WHERRETT: Mr. Chairman, I represent







1 the Canadian Tuberculosis Association, and I have  
2 with me Dr. Jeans, who is Secretary of the Canadian  
3 Thoracic Society, which is the medical section of the  
4 Canadian Tuberculosis Association.

5 The Canadian Tuberculosis Association, as  
6 you know, is a voluntary organization. The first  
7 order of its constitution said it was to be an  
8 organization whereby medical and lay people could  
9 combine to control and provide the means to treat and  
10 prevent tuberculosis. Now, it isn't our purpose  
11 this morning to present anything in the way of a brief;  
12 we will do that later at the meeting in March. But  
13 I did want to say to the Commission that we welcome  
14 the invitation of the Commission to present a brief,  
15 and I should like to indicate a few reasons why we  
16 think tuberculosis should be considered and some of  
17 the particular problems which should be studied.

18 1. While great progress has been made in the  
19 control of the disease as a cause of death in Canada  
20 it is still a major health problem, indeed the full  
21 significance is masked at the present time because  
22 newer methods of treatment have prevented deaths  
23 and shortened the period in hospital. Many patients  
24 formerly in hospital are now on drugs at home.

25 2. A study of trends indicates that while  
26 deaths have fallen over 90 per cent in ten years, morbidity,  
27 as indicated by cases reported, has declined by only 50  
28 per cent. While the length of treatment in hospital  
29 has been reduced by as much as two-thirds there are  
30 still some 12,000 hospital beds reserved for TB, with







1 8,000 in hospital on any one day and approximately  
2 16,000 still on drug treatment at home. It is  
3 estimated that there are 200,000 Canadians who have  
4 had sanatorium treatment and require some supervision.  
5 Of this number over 3,000 are re-admitted to hospital  
6 for reactivation of their disease each year.

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1 3. Tuberculosis is still a costly disease.  
2 In 1960 the cost of operating treatment and preventive  
3 services was in excess of 30 million dollars, and there  
4 are many other preventive services that are not included.

5 4. The Management of tuberculosis has  
6 changed with the emphasis on drug treatment rather than  
7 prolonged hospitalization and rest. This means that the  
8 emphasis has changed from institutional treatment to home  
9 treatment and supervision. This has created a problem in  
10 that public health and clinic services are finding diffi-  
11 culty in coping with this increased work.

12 5. Certain particular problems present  
13 themselves. While it is reasonable to assume that there  
14 should be fewer cases of tuberculosis in the 25-45 age  
15 group in the next 10 to 20 years, the level of tuberculo-  
16 sis among older men will probably fall more slowly because  
17 it is to a greater extent the result of breakdown of old  
18 infection. Drug resistant organisms may also lead to the  
19 persistence of a certain level of tuberculosis. Thus,  
20 special provision for tuberculosis will need to be main-  
21 tained in the foreseeable future.

22 With the increase in the proportion of the  
23 population who have never been exposed to natural infec-  
24 tion it is increasingly important that all new cases should  
25 be notified. The chest physician should work closely with  
26 the MOH on the epidemiological and preventive implications  
27 of the disease, and with the general practitioner, social  
28 worker, and health visitor in helping the patient and his  
29 family to meet their varied medical, personal and economic  
30 needs. The role of the GP in the prevention and treatment







1 of tuberculosis will be increasingly important. Careful  
2 epidemiological study of each new case, especially in  
3 childhood, and attention to groups at special risk, such  
4 as middle-aged men, will become of increasing importance  
5 as the incidence of clinical cases diminishes.

6           6. The matter of staff for tuberculosis  
7 services is of particular concern. Due to the fact that  
8 it is a contracting service younger medical men are not  
9 attracted to the service. It is believed by many that  
10 integration into general medical care services will be the  
11 policy of the future. While a certain number of full-time  
12 key personnel will be necessary, in many instances tuber-  
13 culosis could be cared for by internists and general prac-  
14 titioners. This may call for a change in remuneration of  
15 tuberculosis physicians.

16           7. As the use of treatment beds gradually  
17 falls it may be more practical to treat tuberculosis in  
18 special wards of general or chronic disease hospitals.  
19 This also may call for a change in policy in the methods  
20 of financing hospital and sanatorium services. At the  
21 present time they are mainly financed from health depart-  
22 ment budgets. Some consideration will need to be given  
23 to integrating these services with general hospital ser-  
24 vices.

25           8. The use of national tuberculosis grants  
26 in relation to the change of emphasis from prolonged insti-  
27 tutional to clinic and home supervision in tuberculosis  
28 control needs to be studied.

29           9. The keynote of prevention of tuberculo-  
30 sis rests on the prompt diagnosis and treatment of all





1 active cases. To this end we recommend:

2 a) A study to determine the scope and  
3 coverage of tuberculosis clinics and  
4 dispensaries, not only for follow up  
5 purposes but for the use of medical  
6 practitioners for referral purposes  
7 for diagnosis and for the routine  
8 examination of contacts.

9 b) An investigation of the use that is  
10 made of tuberculin testing and X-ray  
11 examination of population groups of all  
12 kinds to discover hidden cases of the  
13 disease.

14 c) The use and adequacy of tuberculosis  
15 case registers in Canada. We think these  
16 are the basis of the control of tubercu-  
17 losis, and yet they are not as comprehen-  
18 sive as they should be.

19 d) The use and efficacy of BCG vaccine  
20 for the prevention of tuberculosis in  
21 persons exposed to the disease.

22 I think at this time we should study this  
23 matter, and perhaps re-appraise our approach to the  
24 problem.

25 We will be prepared to present a brief, as  
26 I say, at the meeting in February, and if our Association  
27 can be of any help to the Commission we shall be pleased  
28 to do so.

29 THE CHAIRMAN: We are very much obliged to  
30 you, Dr. Wherrett.





1 THE SECRETARY: The Canadian Hospitals  
2 Association.

3 MR. GEORGE McCracken: Mr. Chairman and  
4 members of the Commission, my name is George McCracken.  
5 I am representing the Canadian Hospitals Association.  
6 We are a federation of all of the provincial hospital  
7 associations and the Catholic Hospital Conference of  
8 Canada. Since almost all of the hospitals are members  
9 of their provincial associations, therefore we are  
10 speaking today for the hospitals of Canada. We are  
11 pleased to have the opportunity to submit a brief to  
12 this Commission. It will be forthcoming at a later date.  
13 In this brief we will be prepared to make comments under  
14 those Terms of Reference which we believe relate to hospi-  
15 tals. The purpose of this preliminary hearing, as we  
16 understand it, is to direct the Commission's attention to  
17 what we consider to be important areas. We feel that as  
18 hospital services are such an important part of the total  
19 health picture, that we would expect the Commission to  
20 want to study all phases of hospital operation, but more  
21 specifically we suggest that you direct your attention to  
22 the following points.

23 The impact of the government hospital  
24 insurance plans on our system of voluntary hospitalization,  
25 and the need to maintain and strengthen this voluntary  
26 system, particularly as it relates to the function of the  
27 local Board of Trustees.

28 (2) A study of the availability of hospital  
29 personnel, their training and education, and their most  
30 effective utilization.







1 (3) The question of determining standards  
2 of hospital care.

3 (4) The provision of a balanced program of  
4 hospital facilities. This would encompass acute, chronic,  
5 convalescent and rehabilitated care, with a study of alter-  
6 native facilities.

7 You have already heard from Father Danis of  
8 the Catholic Hospital Association of Canada this morning  
9 that we hope to submit one brief through the Canadian  
10 Hospitals Association, which will speak for all hospitals  
11 in Canada. We have been asked by our provincial hospital  
12 associations to speak on their behalf. It may be that our  
13 provincial associations, or the Catholic Hospital Associa-  
14 tion of Canada, may wish to submit a supplementary brief  
15 relating to specific problems of their own, but in general  
16 we hope that the Canadian Hospitals Association will speak  
17 with one voice for all the hospitals of Canada.

18 That is all Mr. Chairman, thank you.

19 THE CHAIRMAN: Thank you, Mr. McCracken.

20 THE SECRETARY: The Canadian Podiatry Asso-  
21 ciation.

22 DR. P.C.M. LADELPHA: Mr. Chairman and  
23 members of the Royal Commission on Health Services: my  
24 name is Paul Ladelpa, and I am immediate past President  
25 of the Canadian Podiatry Association, Ontario representa-  
26 tive of the Canadian Executive Council, and Federal  
27 Affairs Officer of the Association.

28 My original intention was to attend solely  
29 as an observer, but after hearing the briefs which have  
30 been presented, I felt I would like to offer a verbal





1 submission on behalf of my profession, and to express our  
2 sincere appreciation of your efforts, and to introduce  
3 ourselves to you, since we realise that podiatry is  
4 perhaps not as well known as other specialized fields of  
5 practice.

6 This is merely a preliminary statement by  
7 the Canadian Podiatry Association to express our desire  
8 and willingness to assist the Royal Commission in its  
9 investigations aimed at providing better medical care  
10 for the people of Canada.

11 I might mention that the Canadian Podiatry  
12 Association was incorporated under the laws of Canada,  
13 and exists for the purpose of bringing Podiatrists together  
14 for the dissemination of knowledge and the encouragement  
15 of the highest standards of practice.

16 The Provinces have their own associations,  
17 whose workings are correlated by the Canadian Podiatry  
18 Association, and who have among their other responsibilities  
19 that of regulating and policing the profession.

20 The Podiatrist, or foot specialist, is, for  
21 the benefit of clarification as to definition, a practitioner  
22 of the healing arts who restricts his practice to the  
23 care of diseases, deformities, defects, and disabilities  
24 of the lower extremities, particularly the feet, and is  
25 concerned with the diagnosis, and preventive, medical,  
26 surgical and rehabilitative treatment of these conditions.  
27 His education consists of one to four years of pre-podiatry  
28 study, followed by four years in an accredited podiatry  
29 college. On successful completion of the course of study,  
30 he is granted his doctorate degree and must then sit for,







1 and pass, licensure examination, in the province in which  
2 he hopes to practice, before his name is added to the  
3 register, and his licence to practice issued. Some regions  
4 require a period of internship following graduation. The  
5 podiatrist just described, exists as such, and with such  
6 educational qualifications, only in North America, and  
7 must not be associated, or confused with, medical auxilia-  
8 ries which exist in other parts of the world, but who are  
9 not doctors, and do not possess the medical and surgical  
10 knowledge of the podiatrist in Canada or the U.S.

11 The Canadian Podiatry Association and the  
12 various provincial Associations will submit detailed  
13 briefs during the Commission's future hearings and we wish  
14 at this time, only to draw a few points to your attention  
15 for investigation and consideration:

16 1. There is not nearly a sufficient number  
17 of podiatrists in Canada to meet the foot-health needs of  
18 our Nation; and it is imperative that we encourage young  
19 people of high academic standing to study podiatry.

20 2. Since there is no college of podiatry in  
21 Canada, students must travel to one of the accredited  
22 colleges in the United States. This means they must often  
23 travel long distances from home and may decide, as some do,  
24 to remain in the U.S.A. after graduation and consequently  
25 are lost to Canada.

26 Furthermore, Canada should be able to train  
27 its own professional men.

28 3. Since there is no national council exami-  
29 nation for podiatry, as there is for medicine, provinces  
30 vary somewhat in their legislation. A national council





1 examination would ensure the establishment of a uniformly  
2 high standard of licensure and registration throughout  
3 the country. At present, provinces with the best forms  
4 of legislation attract more doctors of podiatry and as a  
5 consequence, there is unequal distribution of skilled men  
6 in proportion to the needs of the population. Some  
7 provinces have no podiatrists at all because of their lack  
8 of proper legislation, with the result that, if I may use  
9 some of the words of my learned colleague representing the  
10 Canadian Medical Association, "Quacks, Charlatans and  
11 Magicians", and I may paraphrase by saying, "untrained  
12 persons in general", are gaily subjecting suffering people  
13 to improper, incorrect or ancient methods of treatment.

14 We respectfully request that the Royal  
15 Commission should investigate and consider why our citi-  
16 zens must put up with the sadly neglected situation  
17 respecting foot-care in Canada as a result of the afore-  
18 mentioned facts and strive to assure that all Canadians  
19 can receive the best foot-care in the world; not just  
20 some of them.

21 THE CHAIRMAN: Thank you very much, Dr.  
22 Ladelpha.

23  
24  
25 -

26  
27  
28 -

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30





1 THE SECRETARY: Victorian Order of Nurses  
2 for Canada:

3 MISS LEASK: Mr. Chairman, and members of  
4 the Commission, I am Miss Jean Leask, the Director-in-  
5 Chief of the Victorian Order of Nurses for Canada.

6 The Victorian Order believes that the  
7 provision of care for patients at home is an integral part  
8 of any community health service and is an important  
9 aspect to be considered in a study of health services  
10 in Canada. As a public health organization primarily  
11 concerned with providing visiting nursing service, it  
12 is the desire of the Order to cooperate to the fullest  
13 extent in the study being undertaken by the Commission.

14 A short statement outlining the Order's  
15 pattern of organization at the national, provincial  
16 and local levels has already been submitted. We would  
17 like to suggest that this statement be taken as read.

18 At this time we would also like to state that  
19 we expect to make the following submissions to the  
20 Royal Commission on Health Services.

21 (1) A preliminary statement from the  
22 national organization to be presented  
23 at the first public hearing which would  
24 give background material relating to  
25 its historical development in Canada  
26 and to the overall policies accepted by  
27 all its branches.

28 (2) A provincial submission to be  
29 presented at a public hearing in  
30 provinces in which Victorian Order







1 branches have been established, giving  
2 the details of services offered in  
3 that province and problems or  
4 recommendations peculiar to that  
5 province.

6 (3) A comprehensive brief from the  
7 national organization to be presented  
8 at a public hearing of the Commission  
9 after the provincial submissions have  
10 been made.

11 THE CHAIRMAN: Thank you very much. Ladies  
12 and gentlemen, that concludes the list of those who  
13 have registered and indicated an intention to make  
14 a submission here. Anyone present who would wish to  
15 make any statements or representations is free to do  
16 so now.

17 Is there anyone who has any suggestion to  
18 offer within the ambit of our inquiry, of course?  
19 We would be very pleased to hear from them now.

20 Now additionally to the submissions which  
21 have been made, we had received a number of written  
22 submissions, suggestions, which the secretary will  
23 now place in the record.

24 THE SECRETARY: Those organizations, Mr.  
25 Chairman are:

26 Survey of General Practice of Canada  
27 School of Home Economics - The University  
28 of British Columbia  
29 Statement of Principles - Miss Grace Stewart  
30 Ontario Osteopathic Association.





1 THE CHAIRMAN: All of these statements will  
2 be incorporated into the record and will be available,  
3 of course, to the Commission, or anyone else who may  
4 wish to secure a copy of the record.

5 STATEMENT FROM THE SURVEY OF GENERAL PRACTICE OF  
6 CANADA, SCHOOL OF HYGIENE, UNIVERSITY OF TORONTO

7 Statement prepared by Kenneth F. Clute, B.A., M.D.,  
8 F.R.C.P.(C) Director, Survey of General Practice of  
9 Canada and Director of Field Studies, Department of  
10 Public Health, School of Hygiene, University of  
11 Toronto.

12 THE WORK OF THE SURVEY OF GENERAL PRACTICE OF CANADA

13 The Survey of General Practice, which was  
14 instituted by the College of General Practice of  
15 Canada and which has been financed partly by a Public  
16 Health Grant, partly by a grant from the Canadian  
17 Life Insurance Officers' Association, and mainly by a  
18 grant from the Rockefeller Foundation, has been carried  
19 out, during the past five and a half years, in the  
20 Department of Public Health of the School of Hygiene  
21 of the University of Toronto.

22 To determine the adequacy of the quality of  
23 general practice and to determine how adequate present  
24 methods of medical education are as preparation for  
25 general practice have been among the major objectives  
26 of the Survey. In the course of the Survey, visits  
27 have been made to a random sample of general  
28 practitioners in Ontario and in Nova Scotia. With  
29 each of these practitioners, 86 in number, either the  
30 Director or one of his associates has spent a period  
of several days, during which they have been with







1 the practitioner from first thing in the morning  
2 until he has finished his day's work, often late at  
3 night. Having accompanied the practitioner on his  
4 hospital rounds and his house calls and having been  
5 present in his office as he questioned his patients,  
6 examined them, and carried out various diagnostic and  
7 therapeutic procedures, the Director and his associates  
8 have had a first-hand view of general medical practice  
9 in Ontario and Nova Scotia.

10 In addition, by means of a very extensive  
11 questionnaire which has been filled in with the  
12 practitioners during the course of the visits, the  
13 Survey has obtained a great deal of information about  
14 the practitioners' medical education, undergraduate  
15 and postgraduate, about their practice experience,  
16 and about various other matters.

17 At present, the Director is engaged in writing  
18 a comprehensive report of the Survey's findings, which  
19 will be published by the University of Toronto Press in  
20 about a year's time. This report will include a  
21 discussion of certain aspects of medical education and  
22 of the organization of medical care and will make  
23 certain recommendations which, if implemented, might  
24 be hoped to result in an improvement in the quality  
25 of medical care.

26 NEED FOR FURTHER STUDIES

27 As the Director has considered the Survey's  
28 findings, it has appeared to him that there are certain  
29 matters that need to be elucidated by further study.  
30 Amongst these are some that are thought to be appropriate





1 for investigation by the Royal Commission. It is,  
2 therefore, recommended to the Commission that the  
3 following problems be studied:

4 1. Factors that are determining young persons'  
5 decisions regarding a medical career. It is said by  
6 medical educators that students applying to enter the  
7 medical schools are inadequate both in number and  
8 in quality.

9 (a) Why are students not choosing medicine  
10 as a career?

11 (b) What factors are determining whether  
12 the medical graduate chooses general  
13 practice or a specialty as his career?

14 2. The economic situation of medical teachers  
15 in the clinical departments, many of whom are paid token  
16 honararia at most for their teaching and/or research  
17 and/or the care of patients in the teaching beds.

18 (a) How much time are these men giving to  
19 these activities?

20 (b) What is their remuneration for these  
21 activities?

22 (c) What is the effect of giving time  
23 without adequate remuneration

24 (i) on the number of hours per day  
25 that they must work in order to  
26 earn an adequate living?

27 (ii) on the fees that they must charge  
28 their private patients in order  
29 to make an adequate living?  
30





(d) Do these voluntary clinical teachers have adequate time to devote to the preparation of their teaching and to the teaching itself?

(e) How much would it cost to pay medical teachers adequately?

3. The adequacy of postgraduate medical training as presently carried on in internships and residencies (1) in teaching hospitals and (2) in non-teaching hospitals. Evidence gathered by the Survey of General Practice suggests that in many cases the training is not adequate preparation for general practice.

(a) What types of experience does the interne or resident obtain?

(i) What types of case does he learn to handle?

(ii) What types of case does he not learn to handle?

(iii) Does he learn all the procedures that he should be learning?

(b) Is the supervision of the work of the interne or resident adequate?

(c) Reading and study.

(i) What are the interne's or resident's habits?

(ii) What are the example and advice of the staff?

(iii) Are adequate facilities available -- library, study space, etc?

(d) Provision, if any, for evaluation by the







- 1 hospital of the interne's progress.
- 2 (e) To what extent is the interneship or
- 3 residency truly educational and to
- 4 what extent is it merely service to
- 5 the hospital without educational value?
- 6 (f) At the end of his interneship, is the
- 7 interne ready for the responsibilities
- 8 of independent practice?
- 9 4. The economics of postgraduate training.
- 10 (a) What is the present remuneration of the
- 11 interne or resident? Such data as
- 12 are available indicate that these young
- 13 physicians are grossly underpaid.
- 14 (b) How great is the indebtedness of
- 15 young physicians, from various
- 16 socio-economic backgrounds, at the
- 17 end of postgraduate training of various
- 18 lengths?
- 19 (c) how much would it cost to make the
- 20 interneship and residency truly
- 21 educational by turning over
- 22 to salaried staff those present duties
- 23 of the interne that have nothing to
- 24 do with education?
- 25 5. The economics of private practice of good
- 26 quality.
- 27 (a) How much work of good quality can be
- 28 accomplished by a physician in a given
- 29 amount of time? It is essential to
- 30 now this, if the manpower requirements





1 of a health service of adequate  
2 quality are to be calculated.

3 (b) Are certain types of medical service  
4 more remunerative than others that  
5 call for equal training and ability,  
6 under the present fee schedules? For  
7 example,

8 (i) how does the remuneration for  
9 surgical work compare with the  
10 remuneration for equally skilled non-  
11 surgical work?

12 (ii) How does the remuneration for  
13 skilled history-taking and physical  
14 examination compare with the remuneration  
15 for such mechanical procedures as giving  
16 an injection or suturing a wound?

17 Each of the five topics that are listed above  
18 has been suggested for further study, because it is  
19 believed that each has, and will have in the future,  
20 a bearing on the quality of practice available to the  
21 people of Canada.







1 STATEMENT OF THE UNIVERSITY OF BRITISH COLUMBIA,  
2 SCHOOL OF HOME ECONOMICS

---

3 It is the belief of the faculty members of  
4 the School of Home Economics at the University of  
5 British Columbia that Home Economics, through its  
6 various professional branches, has a great deal to  
7 contribute in the field of health and health services.  
8 The promotion and protection of health is of prime  
9 interest to Home Economics.

10 The Home Economics program in university  
11 prescribes courses in normal nutrition as being vital  
12 for all registered students. Those who elect a  
13 dietetic major proceed to more advanced courses in  
14 which normal dietary needs are modified for therapeutic  
15 and other purposes. The majority of graduates  
16 from this school enter the teaching profession and in  
17 their classrooms give health education. Their  
18 potential contribution in this area is not used to the  
19 fullest extent by their schools.

20 The development of health services by a  
21 government body must be accompanied by health  
22 education at all levels.

23 The basis of good health and physical  
24 fitness is laid in childhood in the home and the  
25 school. In order to inculcate in the minds of all  
26 children the principles of good nutrition and good  
27 health habits with an appreciation of their  
28 contribution to general well-being, "Health" should  
29 be a part of every teacher's classroom program. Thus  
30 every teacher should have a sound background in basic





1 scientific nutrition and health. All matters pertaining  
2 to these areas cannot be left to "Health Teachers".

3         The teenage pupil is most vulnerable to  
4 fads, fancies and personal abuse in health matters.  
5 Not only is a sound pointed education in nutrition needed  
6 but also standards for relationship between rest, work  
7 and recreation to give a balance to living. The use  
8 of money and general consumer practices are linked  
9 closely with this. The home economics teacher  
10 is prepared to teach this and should have the opportunity  
11 to present such topics to senior classes of boys and  
12 girls, who will soon be establishing homes.

13         The need for health information has more  
14 immediacy for the young mother. The services of home  
15 economist-nutritionists should be available for  
16 homemakers to assist with the solving of problems of  
17 money management, food selection, market practices,  
18 conservation of energy and the accommodation of home  
19 practices to physical handicaps of a temporary or  
20 permanent nature. The home economist makes a valuable  
21 addition to the social welfare team.

22         The nutritionist may be thought to have the  
23 greatest part to play beyond the school in the field  
24 of health, whether she be attached to a public service  
25 or to private business or industry. Her activity  
26 includes advising on the selection of food, its  
27 preparation and consumption; disseminating factual  
28 information; evaluating promotional material for  
29 patent foods and dietary nostrums, and discounting  
30 diet fads. The true value of the nutritionist has not







1 been realized as there have been too few of them.

2 (In the City of Vancouver Health Department there are  
3 two, in the provincial department there is one). It  
4 is true that the public health doctors and nurses deal  
5 with nutrition, in many cases most efficiently.

6 However, this is not their main interest and may take  
7 second place in emphasis in their work with the public.

8 In connection with the above a determination  
9 and evaluation should be made of what is included  
10 in professional curricula with regard to nutrition.  
11 This should be followed by recommendations for the  
12 inclusion of specific nutrition education in the  
13 professional preparation of medical doctors, nurses,  
14 social workers and teachers.

15 The percentage of our population in the  
16 "aged" group is growing, with more living elsewhere  
17 than with families and most are faced with particular  
18 food problems. To these a nutritionist may give  
19 great help. Regulations should be developed to  
20 control the standard of food service in small  
21 institutions such as boarding homes and nursing homes.  
22 For this nutrition counselling services should be  
23 readily available.

24 The dietitian has her specialized role related  
25 to the service of food in a hospital or in an  
26 establishment catering to the needs of well and active  
27 individuals. She should be involved in committees  
28 that plan health curricula and school lunch programs.  
29 She is capable of doing more in an educational  
30 direction than is allowed for the scope of many







1 appointments.

2 The relation between housing and health  
3 is recognized. In the field of housing the home  
4 economist may serve in the planning of dwelling units  
5 in redevelopment areas, subsidized projects and private  
6 developments. She is prepared to consider the social  
7 and emotional needs of families as well as efficiency  
8 in arrangements for carrying out mechanical activities.

9 School of home economics at universities  
10 may assist with surveys and research.

11 The complexity of the food industry calls  
12 for constant evaluation and control of the use of  
13 food additives, labelling of food container, food  
14 advertising. In order to control these more effectively  
15 a program of cooperative planning should be established  
16 between the personnel of the Food and Drug Directorate,  
17 the medical profession, Food Technologists, Home  
18 Economists, Nutritionists and representatives from  
19 the Canadian Association of Consumers.

20 Many home economics students are interested  
21 in the field of public health. This pool of interest  
22 could be quickly activated if there were known  
23 opportunities for professional involvement in the  
24 field. A great potential service to the field of  
25 public health has not been used as yet.

26

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STATEMENT TO THE ROYAL COMMISSION ON HEALTH SERVICES

FOR PRELIMINARY HEARING

(Miss Grace Stewart.)

STATEMENT OF PRINCIPLES:- Respectfully submitted to the  
Royal Commission on Health Ser-  
vices, for consideration in  
planning the structure of the  
inquiry into the need for health  
services for the people of Canada.

That: the Commission recognize and protect Indivi-  
dual Freedoms, which are rights guaranteed  
by law and which cannot be subject to majo-  
rity vote or majority pressure.  
Under the Canadian Bill of Rights, Bill C-79,  
paragraph (2) clause (a) Individual Freedoms  
are defined as - the right of the individual  
to life, liberty, security of the person and  
enjoyment of property, and the right not to  
be deprived thereof except by due process of  
law;

That: the freedoms defined above be interpreted  
correctly, with particular attention given  
to one of our most fundamental freedoms,  
"Security of the person". This is our guaran-  
tee by law that - "Thy person is thine own",  
and that there will be no interference by the  
government in matters that concern our body.  
This right may not be abridged, except when  
and by the least extent possible it is neces-  
sary to protect the equally important rights







1 of others, as in the control of contagious  
2 diseases which could cause death if left  
3 unchecked and would thereby infringe on the  
4 rights of others, "the right to life".  
5 That: in determining the percentage of the Canadian  
6 people to whom health services are not avail-  
7 able, the guiding principle be need, rather  
8 than a percentage of the people who have not  
9 the necessary health services.  
10 The people of Canada could be placed in  
11 three categories.  
12 Group (1) - those who by extra effort or  
13 superior talent, have taken advantage of the  
14 privilege of acquiring health services for  
15 themselves, and have entered a prepaid  
16 medical scheme or provided other means to  
17 obtain them.  
18 Group (2) - those to whom health services  
19 are available but who have made no effort to  
20 acquire them, preferring rather to spend  
21 their income on items of luxury or pleasure  
22 and cry to the government for health ser-  
23 vices.  
24 Group (3) - those who, because of ill health  
25 and without shirking any responsibility on  
26 their part, have been unable to enter into  
27 a medical scheme, or to provide the necessary  
28 health care.  
29 That: in the inquiry into the existing facilities  
30 and methods for providing personal health





1 services, the Commission give priority to  
2 those fields of Community Rights, where the  
3 government has a duty, and which are:-  
4 Contagious Diseases: which, if left unchecked  
5 could cause death.  
6 Cancer and T.B.: which are diseases of such  
7 a serious nature that much research and  
8 early treatment are necessary.  
9 Mental Diseases: which, if allowed to run  
10 unchecked, could place the individual under  
11 the control and care of the Government for  
12 an indefinite period.  
13 That: the correlation of any new or improved pro-  
14 gram with the existing services, with a view  
15 to providing improved services be not recom-  
16 mended on a compulsory basis, but if deemed  
17 necessary and advisable, be set up on an  
18 individual basis to those who need it.  
19 That: the method of financing any new or extended  
20 program be financed from the treasury, pro-  
21 viding the recommended service is limited to  
22 a major disease, such as Arthritis, Infantile  
23 Paralysis, Heart Disease, or those mentioned  
24 in the above paragraph (2).  
25 That: the methods of financing health care services  
26 as presently sponsored by management, labour,  
27 professional associations, insurance compa-  
28 nies and in any other manner, be not attempted  
29 on a National Scale but be attempted only for  
30 those in group (3) (as set out on this page)





1 who are unable to enter a scheme of their  
2 choice.  
3 That: a medical scheme for this group be set up  
4 in co-operation with the Prepaid Medical  
5 Group Associations and that the financing  
6 of such a scheme be in the form of a subsidy  
7 paid by the government to the Association,  
8 from the Treasury or some other workable  
9 solution arrived at in consultation with  
10 this Association.  
11 That: priority in the field of health be given to  
12 those major diseases mentioned on page 2.  
13 That: since money from the Treasury is money from  
14 the people, improved or extended services be  
15 set up as finances of the government permit.  
16

17 COPY ONTARIO OSTEOPATHIC ASSOCIATION

18 Affiliated with Canadian Osteopathic Association  
19 Divisional Society of American Osteopathic Association  
20

20 From the office of  
21 Committee on Health Services,  
22 28 Wellesley St. East,  
Toronto 5, Ontario.  
September 16th, 1961.

23 The Secretary,  
24 Royal Commission on Health Services,  
25 Daly Bldg., P.O. Box 1173,  
Ottawa, Ontario.

26 Dear Sir:-

27 Herewith, as suggested in the announcement  
28 of the Preliminary Hearing of the Commission, are some  
29 views from the Ontario Osteopathic Association regarding:-  
30

1. "Areas and Problems to be covered"







1 Of vital concern to a certain percentage of  
2 the Public as well as to the Ontario Osteo-  
3 pathic Association is the inclusion of the  
4 Osteopathic profession under any Plan of  
5 Health Services.

6 All agencies qualified to render Health care,  
7 with an honest interest in the health of the  
8 community, such as displayed by Osteopathic  
9 physicians must be included in any plan for  
10 Health Care Services.

11 2. "Statements of Principles that should  
12 guide the Commission, --

13 Plans should be on a provincial or national  
14 basis rather than on a smaller regional  
15 scope.

16 A patient should have the right to choose  
17 his Medical advisor and vice versa.

18 The patient should be responsible for part  
19 of the fee, except an indigent whose part of  
20 fee would be paid out of a government insu-  
21 rance fund.

22 The scale of fees should be standard for a  
23 given area that shall be arrived at by con-  
24 sultation between the government authority  
25 and representatives of those professions  
26 providing services.

27 The remuneration should be reasonable and  
28 consistent with the high standards of ser-  
29 vice expected.

30 Fee for service basis of remuneration is





1           desirable.

2           Each participating profession should have  
3           representation on advisory and/or administra-  
4           tive boards.

5           Provincial autonomy should be maintained  
6           but there should be some degree of Federal  
7           control to maintain standards of service  
8           and also in matters of disease control and  
9           prevention.

10          It should be recognized that specialists  
11          and consultants must be readily available.

12          All diagnostic aids and services should be  
13          available for all physicians.

14          Fundamental Service should be a General  
15          Practitioner service.

16          In-as-much as the health of the Nation is  
17          the prime consideration, all income brackets  
18          should be included.

19          3. The scope of the enquiry.

20          It is recommended that a study be made of --

21          (A) The manner in which the forces of the  
22          various schools of practice may be used most  
23          effectively and if necessary that consulta-  
24          tions be held with those various groups.

25          (B) The principle causes of the scarcity  
26          or maldistribution of Medically trained  
27          personnel.

28          In conclusion, the Scope of Enquiry should  
29          include the principle of promoting the highest possible  
30          level of Physical, Mental and Social health and should







1 consider the co-operation, and consultation of all groups  
2 or agencies involved in Health Care toward the end of  
3 establishing a program that will effectively improve the  
4 health service rendered to all of Canada.

5 For your information, on May 2nd 1961 the  
6 Ontario Osteopathic Association, in formal business  
7 session passed the following motion --

8 "The Ontario Osteopathic Association is in  
9 favour of total Health Insurance -- in Principle".

10 Yours very truly,

11 (Original signed) Donald A. Jaquith

12 DAJ/NJ: Dr. D.A. Jaquith, D.O.  
Chairman.

13 cc. Dr. D.G.A. Campbell.

14 THE CHAIRMAN: Perhaps I should have said  
15 yesterday when I mentioned that it would be in the record  
16 available from the Official Reporters, that of course  
17 those organizations who have made representations here,  
18 I understand certainly a number of them are quite prepared  
19 to make available on request copies of their documents to  
20 the extent, I suppose, the first run of printing or mimeo-  
21 graphing extends.

22 DR. TROUP: Mr. Chairman, members of the  
23 Commission, I am Dr. Wallace Troup, speaking this time on  
24 behalf of the Canadian Highway Safety Council.

25 This Council is very much concerned with the  
26 mortality and morbidity on the highways and at its recent  
27 meeting it decided to submit a brief to this Royal Commis-  
28 sion. I just give notice of that now.

29 I am sorry I was not able to be here yester-  
30 day and was not aware whether an official notification had





1 been made to the Commission.

2 THE CHAIRMAN: Thank you very much. Is  
3 there anyone else who may wish to say something for the  
4 record here this morning, because if there are no other  
5 submissions to be made or any statements to be made we  
6 will come to the end of this hearing, this phase of the  
7 hearing in any event because naturally the Commission,  
8 members of the Commission will continue to meet to review,  
9 and discuss what we have heard here yesterday and today  
10 and the written submissions that have come in.

11 Now these submissions and recommendations  
12 will be carefully reviewed by our Research Director, by  
13 our Medical Consultant, by our Research Consultant and  
14 by their associates and by the Commission. They will  
15 facilitate and certainly expedite the work of the Commis-  
16 sion because they will enable us to set in motion now  
17 studies and research projects long before the formal and  
18 detailed briefs can be or could have been prepared and  
19 submitted.

20 As I mentioned yesterday what has been said  
21 here yesterday and today will be of great help to others  
22 in the preparation of their briefs and submissions.

23 Those who have favoured us by attending and  
24 by making suggestions and recommendations have greatly  
25 assisted the work of the Commission and we are very grate-  
26 ful to all who have been so helpful. I want, on behalf of  
27 my associates to thank everyone who has been so helpful.

28 This hearing now stands adjourned.

29

30 --- The hearing adjourned.

















